Medical Economics

JULY
1944

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*WOLDMAN, E. E., and POLAN, C. G.: The Value of Colloidal Aluminum Hydroxide in the Treatment of Peptic Ulcer; A Review of 407 Consecutive Cases. Am. J. M. Sc. 198: 155-164 (Aug.) 1939.

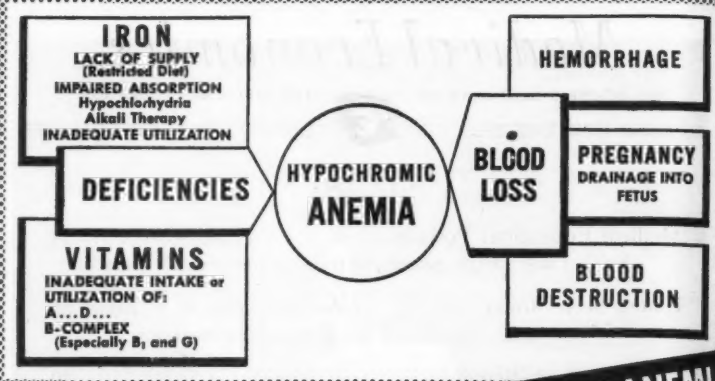
Medical Economics

THE BUSINESS MAGAZINE OF THE MEDICAL PROFESSION

JULY 1944

CIRCULATION 110,000

H. Sheridan Baketel, A.M., M.D., Editor-in-Chief. William Alan Richardson, Editor. Ross C. McCluskey. Managing Editor. Lansing Chapman, Publisher. Russell H. Babb, Advertising Manager. 25c a copy, $2 a year.



Treating the Patient IN HYPOCHROMIC ANEMIA

The nutritional deficiency which frequently causes hypochromic anemia is rarely restricted to iron alone. Insufficient iron intake usually is linked with deficiencies of other nutrients vital to blood normalcy. But whether the anemia is caused nutritionally or by blood loss, a vicious cycle generally comes into operation: Anemia engenders anorexia and hypochlorhydria, thus inhibiting adequate intake and absorption of needed nutrients; their lack, in turn increases the severity of the anemic state. In therapy, to aim at the iron deficiency alone means to treat merely a symptom; treating *the patient* calls for more complete measures.

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Speaking Frankly

Hospital Offices

As a wartime expedient, the Evanston Hospital's provision of private-practice offices for its staff physicians has certain advantages. But in normal times I seriously doubt the wisdom of such an arrangement, for these reasons:

1. The staff man would enjoy privileges not available to the non-eligible physician. 2. The hospital would be brought more and more into the field of medical practice. 3. Hospitals are often inaccessible to the majority of patients. 4. Private practitioners of radiology and pathology would find the arrangement objectionable.

M.D., North Carolina

Hardly practicable for a good many cities whose hospitals are in the suburbs.

M.D., South Dakota

It's a good idea. Staff appointments are not being cherished today; many of the older men are resigning because of pressure of outside practice. Hospital staff officers would create interest in desirable appointments and would help remove economic competition for the man who wishes to be a good physician—not a stylish one.

M.D., Connecticut

Union Health Center

Your article about the ILGWU's Union Health Center reveals how truly the machine age has invaded the practice of medicine. In such an undertaking, stress is always laid on modern testing equipment and the fact that specialists are available. Is that enough?

Just now I am treating a patient who went through an industrial clinic for an abdominal condition accompanied by pain. X-rays were taken in the clinic of the patient's gall bladder and kidneys, and electrocardiograms were made; but no diagnosis followed.

When the patient came to me I did what no clinic can normally do—spent a great deal of time checking his history. It revealed that the symptoms dated back several years to a time when they had been accompanied by vomiting. A test meal and simple fluoroscopy revealed a definite duodenal ulcer.

The value of the UHC type of clinic lies in its ability to spot early tuberculosis, diabetes, or nephritis. I believe that's as far as such an institution should go. Proper care should be left to the well-trained medical man who is not too rushed to be painstaking.

Monroe B. Kunstler, M.D.
New York, N.Y.

The UHC shows what can be done with group medicine in industry, provided it is well-financed and well-managed. It is especially advantageous in preventive medicine.

However, I doubt that the suc-

cess of the ILGWU plan, the Kaiser plan, and others like them justifies the assumption that any governmental scheme would be equally successful. There's a big difference between a well-run private plan limited to an industry and a gigantic Federal organization.

M.D., Ohio

I see no objections to such a center. Most of its patients would otherwise go to free clinics anyway.

M.D., New Jersey

Group practice should be free of any outside control—industrial, union, state, or Federal.

M.D., Utah

The Union Health Center is just another instance of a group by-passing the AMA, which should have set up prepayment plans years ago. It also means that an enlightened public will not further tolerate anti-social, reactionary stupidity from any organized profession—medical or otherwise. American medicine is big business. It needs intelligent management. Yet its affairs are run by men who lack the qualities of leadership.

H. M. Wiley, M.D.
Cincinnati, Ohio

UHC doctors are grossly underpaid.

M.D., New York

1. Considering that UHC physicians have no cost of operation and that their pay is net, the hourly rate is adequate.

2. Furnishing eyeglasses and prescriptions at a price under usual retail figures is all right as long as it is recognized that with large volume, the overhead per item is de-

creased. It is not fair to expect a good pharmacist, who has an uneven demand for his services but has to be completely stocked, to compete with someone doing a wholesale business.

3. You say that the ILGWU keeps hands off in all medical matters. If this is strictly true, and physicians make diagnoses and give advice entirely on scientific grounds and without interference, the situation is eminently correct.

4. I note the regulation restricting issuance of a union card, if an applicant for membership is unable to pass a required physical examination. For some years I have felt that many unions are badly mistaken in opposing physical fitness examinations required by employers. The person who wants to work is the real sufferer in such a quarrel.

5. Since the union gives only limited coverage to its members, one cannot apply its cost to plans involving complete coverage. Does the union have reliable figures as to what additional costs its members incur for medical and dental attention not provided by the union?

George H. Hyslop, M.D.
New York, N.Y.

Personality vs. Brains

Your report on what the public likes and dislikes in doctors pointed up much that I have discovered in forty years of practice. It explained why men in the lower scholastic brackets in medical school may sometimes be found, ten or twenty years afterward, doing the biggest business. People pay more attention to personality than to character or brains; they have no accurate standard for assaying a physician's fitness. Shall we spend as much time trying

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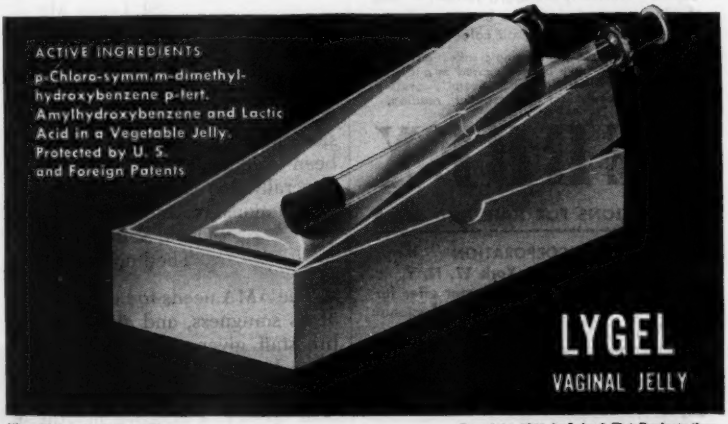


"Lygel" Reg. U. S. Pat. Off.

to please the public as trying to prescribe medicine scientifically?

Paul R. Howard, M.D.
Chicago, Ill.

AMA and Politics

Can the American Medical Association be made an effective political instrument? Yes—if each member is given the right to voice his sentiments by secret ballot. That is what is done in the British Medical Association on matters of national policy.

At present the AMA is run by men who have held their official positions for years. Dr. Fishbein and others on salary may have some voice, but actually they are office boys for the House of Delegates.

The house does not represent the profession; it maintains its membership by indirect voting and political maneuvering. It will take years of difficult work to overhaul AMA officialdom; but eventually, I believe, forces from the outside will relieve the association of its control of the profession.

M. J. Bierman, M.D.
St. Louis, Mo.

The AMA cannot be made an effective national political instrument because it has never been really representative of the medical profession. Medical politics have always been local or regional, with doctors generally too absorbed to bother with national matters.

David S. Rausten, M.D.
Thedford, Neb.

The AMA needs to be shaken out of its smugness, and almost its entire staff given to understand that the ordinary doctor does not approve the "sit tight and don't rock the boat" policy. I approve heartily of

Dr. Parsons' suggestion in your May issue that physicians study the feasibility of reorganizing the association.

M.D., Nebraska

Ninety per cent of us have been jumping through the hoop simply because there is no other reputable national organization which we might join.

M.D., Missouri

Record me as opposing any new bureau in Washington, D.C. I believe that doctors should appeal directly to their representatives in Congress.

W. H. Luedde, M.D.
St. Louis, Mo.

G.P. and Specialist

Many of my colleagues have evinced concern about the postwar ratio of specialists to G.P.'s. Each is agreed that those specialists who have undertaken general practice for the duration will return to their specialties after the war. In addition, a great many demobilized medical officers will seek to specialize, especially those who have been getting a lot of experience in surgery.

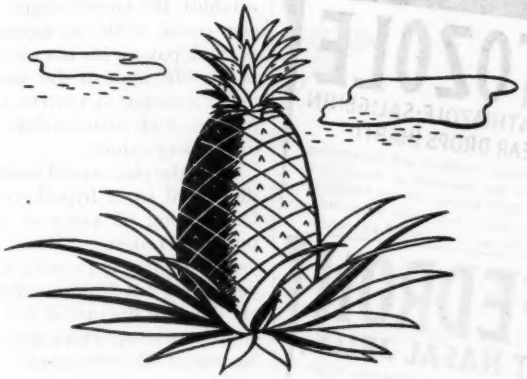
Result: an undersupply of general practitioners and an oversupply of specialists.

M.D., Ohio

Life Memberships

Private physicians today are enjoying the largest practices of their careers. Income taxes, however, are extremely high, may even go higher. Hence, careful consideration should be given to every suggestion that affords a tax saving.

If county medical societies would



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- **Its refreshing flavor appeals to dulled appetites of adults and to the finicky tastes of children.**
- **It's convenient to use—just "punch and pour."**

establish life memberships, a physician could, while his income is abnormal, pay up his dues for the rest of his life—and, at the same time, make a saving in current taxes. At present, such memberships are virtually nonexistent.

How the plan would work may be illustrated by a hypothetical case. Considering 65 years of age as a probable retirement time, the 45-year-old physician would, in twenty years, pay out $300 in county society dues (at the rate of $15 a year). If such a doctor, with a present gross income of $15,000, could purchase a life membership for $300, he could make a total saving of about $129—the life membership would actually cost only $171 (he would avoid the payment of a 43 per cent surtax on the cost of his life membership, which is deductible as professional expense on his current year's return).

Naturally, he would not be able to make his annual $15 deduction any longer; but if his income leveled off in subsequent years, his surtax rate would shrink accordingly. Meanwhile, he would have a saving at the present high rate, plus his eventual saving in dues.

With the establishment of the life memberships, medical societies should consider the creation of endowment funds. Otherwise, the dues from such memberships would probably go into general funds and gradually evaporate.

The American College of Physicians established life memberships and an endowment fund many years ago. These are described in a booklet, "Membership Without Dues." I have been told by the secretary-general of the college that the plan has been highly successful. [*turn page*]

Confirming Data—Expanding Use

Successful clinical experience, as reported in leading medical journals, has greatly broadened the interest in Amino Acid therapy. With a fuller appreciation of this therapeutic agent, physicians are rapidly extending its use to combat protein malnutrition.

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Aside from gaining the personal advantages inherent in life memberships, physicians would be helping to place their county societies in a stronger financial position—a position which would enable them to broaden their activities in the fields of medical economics, public relations, and so on. Moreover, the establishment of a soundly managed endowment fund should encourage many a physician to make outright gifts to his society or to remember it in his will. We all owe a debt of gratitude to our profession; yet physicians as a group have not been generous with their own organization. It is high time that efforts were made to stimulate thought in this direction.

Other groups have learned the value of collective action—which is made possible by financial reserves. Labor, for instance, sees to it that every workman contributes liberally—on a compulsory basis. Medicine, of course, prefers voluntary contributions; but the lesson of group action, yet to be learned by our profession, is fundamentally the same.

In making arrangements to accept contributions from members, county societies should carefully scrutinize the wording of the "Object" clause in their constitutions; for it must be remembered that gifts are not deductible on Federal tax returns unless made to an organization whose purpose cannot be questioned. In this connection, county societies can do no better than follow the example of the tax-exempt AMA, whose stated objective is "to promote the science and art of medicine and the betterment of the public health."

—HAROLD SWANBERG, M.D.
Quincy, Ill.

Sidelights

It was evident last month that our best efforts would be needed to figure out how, in view of the curtailed Army training program, the supply of students in medical schools could be maintained at a reasonable level.

The AMA House of Delegates felt that the key to the solution lay in Washington, so it demanded immediate action by the President or by Congress to permit the enrollment of more medical students.

If this action were not forthcoming, it warned, the Government might as well resign itself to "an over-all shortage of qualified physicians, with imminent danger to the health and well-being of our citizens."

Mr. Roosevelt's personal physician, Navy Surgeon General Ross McIntire, addressed the House of Delegates on the problem, but indicated no likelihood of action by the Chief Executive. In fact, he appeared to toss the issue back into the laps of his listeners by suggesting that they give it their "combined consideration."

All in all, Congress seemed to be the most likely source of aid in maintaining an American medical-student body of adequate size. It could scarcely fail to consider so pressing an issue.

All it needed was a polite touch of the spur.

We mean the AMA Council on Medical Service and Public Relations, which during its first six months, accomplished virtually nothing, yet which now promises to accomplish a great deal.

This is good news. For the council has before it the monumental job of evolving "such modifications of our present system of medical care as may be necessary to cover all the people and be in accord with the traditions of American medicine." Every physician wishes it Godspeed.

Quite understandably, the council resents the indignity of having been prodded into action. One of its members—retiring AMA President James E. Paullin—assured the House of Delegates last month that "The results achieved have been accomplished despite the almost hysterical demands from some sources [MEDICAL ECONOMICS, *et al*] for immediate action. . ."

However that may be, the desired effect has been brought about. The council is now busily establishing contacts with lay organizations, expanding its sources of information in Washington, exchanging data with state and county medical societies, surveying sickness insurance, campaigning for medical economics courses in medical schools, issuing legislative bulletins, and so on.

Perhaps its most promising disclosure was one to the effect that it had asked Dr. Joseph Lawrence of Albany, N.Y., to head its new Wash-

ington office. Dr. Lawrence has had rich experience as legislative representative of the Medical Society of the State of New York. Given free rein in Washington, he should be able to accomplish much of value to American medicine.

Carefully avoiding a grin, Dr. Morris Fishbein told a press conference following an executive session of the AMA House of Delegates last month that the ouster proceedings brought against him and Dr. Olin West by delegates from California had been defeated by a vote of 144 to 9.

He then read a reference committee report adopted by the house, which upheld the two AMA employes and was apparently intended to put the California delegation in its place. The committee report said, in part:

"Never before has American medicine been so needful as now of unity... Physicians should give their loyalty and support to those selected by this House... and... by the Board of Trustees." The statement ended on a note calculated to appease the two headquarters men, commending "the loyalty and efficiency with which these officers have for many years served the Association."

Dr. Fishbein neglected to tell reporters that the California resolution requesting his replacement as JAMA editor and the retirement of Dr. West as AMA secretary and general manager had been defeated by a standing vote. Had a secret ballot been taken, as proposed, the two officers might have found themselves much closer to the sign reading, "This Way Out."

Editorial

Correlate Those Postwar Plans!

Postwar planning in medicine gains momentum day by day. Scarcely any scientific organization of national scope is now without some program of the sort.

Which is all to the good.

But what is being done to correlate these activities? The answer, so far, is not encouraging.

A unified policy should be sought in each sphere in which postwar medical planning is under way (*e.g.*, financial aid to demobilized medical officers, relocation, post-graduate study). It is important that this be done before implementation of individual plans begins. It is also important that unification be achieved quickly, so that adequate time will be available for action.

As an example of uncorrelated activity, consider the present planning-in-all-directions for post-graduate medical training. It includes

1. A broad-scale fact-finding study initiated by the Advisory Council for Medical Education;

2. A similar investigation under the aegis of the American Medical Association;

3. An American Hospital Association survey financed by the Kellogg Foundation ($100,000);

4. A program of the American College of Surgeons to find out how best to expand graduate training in surgery.

There are other plans, too; although these comprise the top stones in the pyramid. Beneath them the structure broadens to include a host of lesser national programs. And at the base are unnumbered county medical society plans, most of them yet uncrystallized.

Uncorrelated effort is almost equally evident among plans to give financial aid to demobilized medical officers: Some county medical associations are already engaged in fund-raising on a local scale. The AMA is studying the advisability of doing it nationally. And the Federal Government has undertaken to legislate assistance for its ex-service men at large.

The need for unified postwar medical planning cannot have been overlooked. It is altogether too obvious. Can its absence be explained, then, by the refusal of one group to cooperate in another's work simply because it did not initiate it and would not garner all the credit?

Petty jealousy is intolerable. The problem calls for nothing less than wholehearted teamwork. This suggests the formation as promptly as possible of a competent steering committee on which all planning organizations will be represented. Without such coordination, we'll continue to get nowhere fast.

—H. SHERIDAN BAKETEL, M.D.

Medical Education: Postwar

Post-graduate study due to be broadened, undergraduate curricula revised

Taking shape last month were plans for peacetime medical education, both post-graduate and undergraduate. In an important place on the agenda were the educational problems of demobilized medical officers. Not all studies underway had been announced officially. Some were only local in character. But at least two of national scope gave some indication of what their sponsors hoped to accomplish.

The newer of these two programs was that being undertaken by the Advisory Council on Medical Education, which has set up a nineteen-man committee. Members are widely known educators, a majority of them physicians.

According to Dr. Willard C. Rappleye, president of the council and dean of Columbia University's medical faculty, the study ("if we can do the job, and I think we can") might shape the course of medical education for the next twenty-five years.

Announced as its major aims were:

1. The provision of educational opportunities for discharged medical officers.

2. Establishment of proper pre-medical standards.

3. Revision of medical school curricula to correct the inadequacies of the accelerated wartime schedule and to provide for the changing pattern of medical care expected after the war.

Hospitals and medical schools should plan now to assist demobilized doctors, the council said. Help will be needed for two general groups: (a) those whose training was cut short by the war, and who therefore will require interneships and residencies; (b) those called from active practice, who will need refresher courses before resuming civilian work. In many cases, the council reminded educators, military experience will not have provided training in newly developed techniques.

For the first group, Dr. Rappleye told MEDICAL ECONOMICS, the council recommends hospital residencies and fellowships in qualified institutions. He pointed out that this training, well-established before the war under the aegis of the Advisory Board for Medical Specialties and certain universities, has been maintained during the emergency.

The council believes that discharged medical officers will seek hospital posts for periods of from one to three years. Thus the number of such posts will have to be increased greatly. Many hospitals are now affiliated with medical schools, Dr. Rappleye noted, but he considered it imperative that more ar-

rangements of the sort be worked out at once. It will be particularly necessary, he added, for medical schools to formulate or augment programs in the basic sciences.

The council noted that the demobilized medical officer will be eligible, under the educational and rehabilitation bill recently enacted, for mustering-out pay, tuition expenses, and maintenance.

Dr. Rappleye urged that refresher courses be thirty to ninety days in length and be coordinated in a general way with the postwar programs of the medical schools. The cooperation of all hospitals capable of providing adequate clinical training would be required, he believed.

As far as premedical standards are concerned, the council pointed out that before the war 98 per cent of the country's medical students had completed three years of college work, and 76 per cent had degrees. The fifteen months of study which now gets a man into medical school (under the Army's stepped-up program) is considered wholly indequate by most educators.

Revision of curricula is called for, the council contended, because of the growth of group practice and the expected postwar extension of hospital, laboratory, nursing, and other services to all sections of the country. New emphasis, it said, will be needed on such matters as the legal and economic aspects of medicine, as well as upon such subjects as parasitology, tropical diseases, chemotherapy, genetics, nutrition, aviation physiology, and mental disorders—to mention but a few.

Dr. Rappleye's group said it hoped to make a preliminary report sometime next fall.

AMA PLANNING

Second of the major postwar programs being developed was that of the AMA Council on Medical Education and Hospitals. The council had gathered statistics on the *supply* of interneships and residencies available and likely to be available after the war. Its next concern was to determine the probable *demand* for these facilities.

To accomplish this, a questionnaire was to be mailed to 55,000 medical officers. The council hoped to tabulate results by October or November. Then, armed with data on both the supply and demand for graduate training facilities, it would try to balance the two in its active program.

(A survey of a cross-section of physicians in service was initiated by MEDICAL ECONOMICS some months ago; the results appeared in the June issue. They showed that 56.4 per cent of medical officers planned to take post-graduate work after demobilization; another 18.3 per cent were undecided; only 25.3 per cent had no such plans.)

The AMA council says it expects the demand for post-graduate facilities to be greater than the supply. If this proves so, the council will urge hospitals to provide additional residencies. Here is the procedure it will follow:

1. Large hospitals approved for interneships will be urged to develop residency programs.

2. If necessary, hospitals approved for residencies will be asked to increase their facilities (*e.g.*, a hospital offering three residencies in orthopedic surgery will be urged to offer four or five).

In each case the council will consult with the appropriate specialty board before making overtures to hospitals. Boards will be asked to

[*Continued on page* 104]

Unions Seen Preparing for Huge Health Program

West Coast experiment may set pattern for national drive

Organized labor, long active in developing local medical service plans, is readying its forces for a far more ambitious undertaking: an all-out invasion of the whole area of national health.

No labor leader has actually announced such a program; no broad-scope action is yet visible. But there are the unmistakable signs that the unions are developing a strong strategic position. A beachhead has already been established in California.

How far the movement will go, how long it will take to gain momentum, is anyone's guess. Meanwhile, the age-old struggle between management and labor, once centered on sweatshop conditions and later on wages and hours, is rapidly turning into a clash over the economics of medical care. Employers, whether they realize it or not, are destined to pay—in part, at least, and probably through a payroll levy—for the medical care of their unionized employes, not to mention the families of such workers.

Scores of examples could be cited to show how labor leaders have seized upon health as a means of strengthening the tie between union and union member. Active endorsement of the Wagner-Murray-Dingell bill by both CIO and AFL, which ordinarily have little in common, as well as by the independent factions which refuse to affiliate with either, indicates that all see eye to eye when it comes to a national health program. The widespread development of union-sponsored group-insurance plans is, in itself, sound evidence that labor leaders have become health-conscious in a big way.

Of vital concern to the profession is the matter of control: Will the movement develop more rapidly in the well-run "right wing" unions or in the Marxist groups that might eventually turn it into a system of state medicine? Some physicians, of course, feel that all unions are more or less Moscow-dominated; but the record shows that where medical service plans have been developed by legitimately operated groups, a fair degree of cooperation with organized medicine has been achieved. For this reason, a good many doctors interviewed recently feel that it is now wiser to encourage such cooperation than to ignore the movement entirely.

The beachhead established in California is significant only as a pattern along whose lines the national battle may take form; yet already it has made the San Francisco area a hotbed of controversy.

In that city last January, representatives of various unions—CIO,

AFL, the Railway Brotherhood, and other independents—called a conference to discuss union health problems. It was attended by representatives of organized medicine, public health agencies, and associations interested in tuberculosis control, nutrition, venereal disease, and heart disease. Set up as a result was a joint body, the Northern California Union Health Committee. Its announced purpose: to act as a clearing house for material and information about health activities; to make available to all unions the work of large lay organizations and medical agencies; to release weekly health articles to union publications reaching 200,000 people; to facilitate the work of labor with management and government agencies on educational campaigns dealing with nutrition, communicable diseases, and industrial health; to act as an over-all service committee on health.

Specifically, it listed these objectives:

¶ Mass surveys for T.B. and V.D.;

¶ An amendment to the state resident law making T.B. care available to everyone domiciled in the state;

¶ Larger appropriations for public health services and for health education in the public schools;

¶ Union representation (through advisory committees) in state, county, and city health departments;

¶ Authority for the U.S. Public Health Service to take emergency charge in communities (such as the Harbor Gates area in Richmond) "where there are no facilities";

¶ Union participation in existing prepaid insurance plans, particularly those of the California Physicians Service and the Permanente (Kaiser) Foundation;

¶ Investigation of the problem of preplacement examinations in industry;

¶ Agitation for the passage of the Wagner-Murray-Dingell bill.

Appointed to a "professional advisory committee" were several members of organized medicine, including Dr. Rodney R. Beard, representing the San Francisco County Medical Society, and Dr. A. E. Larsen of the CPS, as well as other physicians representing public health agencies, Henry J. Kaiser, and the tuberculosis association.

Doctors serving on this committee—all members of the county society—are generally opposed to the Wagner bill. How they are to recon-

Quiz Kid

The five-year-old in the wheelchair was recuperating from pneumonia. He wanted to know where in the hospital I worked. "In the laboratory," I replied. "I work with the girls who have been coming down every day to prick your ear. They do a blood count, and then I enter the results on your chart."

"Is that what you're doing now?" he asked. "No," I told him. "Right now, I'm charting a urinalysis." He thought that over for a minute, then asked, "What do they prick to get that?"

—INGE SCHWARTZ

cile this position with union committee service is not clear to many a San Francisco physician. Explained Dr. Beard: "The justification for the union health committee is the present need for the health education of workingmen. Already there has been some modification of the workers' attitude toward the preplacement examination. Unions are not yet coming to ask for such examinations, but there is increasing cooperation and understanding.

"One reason for holding the original conference was to discuss plans for prepaid medical care. Certain physicians considered it a good opportunity to get all views before the union people. I encouraged the county medical society to participate. We were not going to be able to convince union members why the Wagner bill is not a good thing by staying away, by boycotting the meeting. We have a far better chance of getting all sides expressed if we stay on the committee."

Said Dr. Larsen: "The movement would seem to permit all concerned to come together on an organized rather than a personal or haphazard basis." He said the CPS was interested because one aim of the committee was adequate prepaid medical care. "Labor is our consumer," he pointed out. "On that score, we must and should work with them. It is a factual situation that has to be met."

Dr. Larsen implied that CPS service in some instances had failed because it lacked labor's support. As far as the Wagner bill is concerned, he argued that the CPS is a purely local body, and is not entering into political-medical discussions.

Said a county society official (not a member of the union committee): "The society was asked to sit in on the conference but was not allowed to talk. The CIO health director ran the show. It was the typical union thing . . . We have been trying not to quarrel with them. At the conference, they seemed not to approve of the CPS; now they do. We consider that a gain . . . We want to cooperate with labor. We want people to know what the Wagner plan will cost. Also, we wish to explain the advantages of prepaid systems such as the CPS. We hope to get them working with us."

According to another member of the society, the union committee is an excellent idea, but will become a problem if it is used as a sounding board for union propaganda. It might so be used, he thought. "They seem to be proceeding without consideration of opposing ideas."

The attitude of private practitioners was difficult to gauge. Said one specialist: "We regard the committee with a certain amount of foreboding and fear. But you can't get doctors to be frank on these subjects. Organized medicine makes it hard for any who dare to be frank. The county society won't allow discussions of socialized medicine, health plans, and so on."

Funds for the committee have been supplied by the Rosenberg Foundation ($4,000) and by several unions. The professional advisory body, according to Dr. Beard, its chairman, agreed to give advice and guidance, but would not be responsible for fund-raising. He believes that the financial response of the workers will eventually prove whether the committee's work is worth while or not, and that it will take two years to produce such proofs.—JOHN BARTOW & R. F. BOND

Why Patients Switch Doctors

As revealed by a nation-wide personal-interview poll

Why do Americans give up their doctors? Somewhat more than half through necessity, the rest through choice, according to a recent poll conducted for MEDICAL ECONOMICS. Here are patients' reasons:

"I moved"	20%
"He moved"	4%
"He went into service"	18%
"He died"	14%
"He didn't help me"	11%
"I didn't like his personality"	6%
"I doubted his competence"	5%
"He charged too much"	3%

The remaining 19% of respondents cited reasons not readily classifiable.

The sampling was conducted by Fact Finders Associates, Inc., New York research organization. Interviewers—covering urban and rural areas of twelve states*—asked this question: "Why did you give up your last doctor?" Replies represent a cross-section of Americans, diversified by age, sex, location, income, and occupation.

Many respondents, who complained that their former physicians hadn't helped them, said their doctors had been so rushed they couldn't do a thorough job. A Newark insurance salesman, for instance, said he had decided to give up his physician "because he was too busy to give me a complete physical check-up, and refused to refer me to anyone else." A Philadelphia secretary reported that her doctor had been unable to see her at all when she needed him. "I called in another doctor," she added. "He came at once—so I'm going to continue with him."

Of those who had been impelled to make a change because of their doctors' personal traits, a number reported that their old physicians were "pokey," "nosey," "talkative," "independent," "inattentive," or "unclean." Said a Louisville housewife: "He always asked a lot of personal questions that had nothing to do with the case."

A number of respondents had been annoyed by "overcharging."

Said a Pittsburgh mother: "When my two boys had whooping cough, he charged double for each call."

Miscellaneous complaints ran the gamut. "I gave up my last physician because his wife dominated him," said a Youngstown metallurgist. "She is a nurse, and the only way I could reach the doctor was through her. I became tired of answering her endless questions."

Other respondents reported these reasons for changing: "He became a specialist"..."I thought I'd try an osteopath"..."He was a company doctor"..."I thought maybe a woman doctor could help me."

*Cal., Ga., Ind., Iowa, Ky., N.J., Pa., Ohio, Ore., Tex., Wash., Wis.

Colossus of Medicine

The Columbia-Presbyterian Medical Center: Its hospital endowment is largest in U.S.

Rising impressively from the bluff of the Hudson River in upper Manhattan, the Columbia-Presbyterian Medical Center has 1,400 beds and 1,100 clinic patients a day. It is equipped to treat everything from warts to bacterial endocarditis, for it includes one of the greatest concentrations of medical specialists and apparatus in the world. Its purpose: to combine in one center the optimum number of services. Its function: to cure and teach. Its achievement: excellent care for rich and poor.

THE MANY BECOME ONE

In 1911 Presbyterian Hospital became the teaching hospital for Columbia's College of Physicians and Surgeons. In 1921 a joint administrative board tackled the problem of combining hospital and school under one roof, and adding other services. The Columbia-Presbyterian Medical Center was the result of their planning.

Vanderbilt Clinic, Columbia's School of Dental and Oral Surgery, and the DeLamar Institute of Public Health became integral parts of the center. Established institutions, including Sloane Hospital for Women, Babies Hospital, Neurological Institute, and the New York State Psychiatric Institute and Hospital, became affiliated units. Presbyterian's School of Nursing became Columbia's school of nursing. Ground was broken in January, 1925, and construction began on the buildings that were to house the biggest venture in the medical world.

The venture had been made possible by the late Edward S. Harkness. Mr. Harkness bought thirty acres of land, including the site of the old Yankee ball park, for an estimated $4,000,000 and presented it to Columbia University and the Presbyterian Hospital. He and his wife also provided some $18,000,000 for endowment funds and for buildings and equipment, specifically for the Harkness Pavilion (private patients) and the Eye Institute. Others contributed additional millions. Altogether, Presbyterian Hospital now has an endowment of $30,000,000; and when Mr. Harkness' estate is settled it will inherit nearly $15,000,000 more.

INCOME, OUTGO

Last year medical center beds were 76 per cent occupied. Total

► Physicians who wish to read more about the Columbia-Presbyterian Medical Center will find a much longer article, of which this is an approximation, in the June issue of *Fortune*.

number of patients was 29,345, an increase of 1,214 over 1942. Ninety-four per cent of the patients left in an improved condition. Only 2.5 per cent died.

Running expenses of the hospital are supplied almost entirely by fees, voluntary contributions, and income from endowments. For the care of certain charity patients, the city pays a flat rate of $3.25 a day. Last year operating expenses and provision for reserves were $5,003,202. Sixty-eight per cent of the income to match this came from patients (48 per cent from private patients, 13 from semi-private, 39 from ward and clinic). Twenty-two per cent was made up of income from invested funds; the rest, from the United Hospital Fund, the Greater New York Fund, and other donations. Contrary to expectations, large donations have not fallen off in the last few years.

DOCTORS, STUDENTS

No doctor can be appointed to the staff of the hospital until he has had three years' pre-medical training, four years' general medical training, two years' interneship, and two or three years' residency. Presbyterian internes receive maintenance, no salary. Residents are paid about $1,500 a year in addition to maintenance. Full-time professors (paid by the university) make a good deal less money than attending physicians who give half their time free to the hospital and receive their incomes from private patients.

Original idea was to have the staff made up entirely of full-time men, but many doctors refused to give up private practice and the idea was abandoned. The part-time doctors who see their private patients in downtown offices (or in a private-office unit at Harkness Pavilion), may charge as much as they like; but they receive nothing from ward and clinic patients.

Of the 470 students now at the College of Physicians and Surgeons about 10 per cent are women, or men physically unfit for military service; 90 per cent are in service.

The medical center cannot give the students all the clinical experience they need. There is additional work at about a dozen other hospitals.

THE LABORATORIES

The research men have lost some of their young technicians but the most serious effect of the war has been the curtailment of long-standing experiments to make room for military research on burns, shock, malaria, aviation medicine, and penicillin. Some of the peacetime projects, such as work on the circulation of blood in the spleen, have been abandoned; cancer research at the affiliated Crocker Institute has been

Mrs. Moto Thinks Fast

"Want to have baby," the Japanese woman told me at the clinic. I asked her a few questions, then instructed her to take off her dress and panties, lie down on the table, and cover herself with the sheet. "I'll be back in a few minutes," I added, "and then we'll see if you can have a baby." "No, no!" she objected loudly, "want to have *Japanese* baby!"

W. G. DICK, M.D.

Columbia-Presbyterian Medical Center . . .

curtailed. Other projects, however, continue at an almost normal pace.

Some critics of the medical center argue that the very size and affluence of the place inhibit pure scientific research. Others feel that well-trained men working together in well-equipped laboratories have at least an equal chance with the starving hermit scientist to make great discoveries, and that affiliation with clinic and hospital is an asset.

TOO BIG?

By last March the center had been functioning for sixteen years—long enough to prove whether or not its original aims were being realized. To a large extent they were. The teaching standards were as high as those of any top-flight medical schools. P. & S. ranked with Harvard, Johns Hopkins, Cornell, and Yale; it was the first choice of many of the most promising students.

Most patients at the medical center—from Johnnie Rinaldo who paid the standard clinic fees (seventy-five cents) to have a sprained ankle

. . . $22,000,000 was just a start

bandaged to Mme. Chiang Kai-shek who spent weeks in a suite of many rooms at Harkness—would probably agree that they got good treatment. Harkness patients may complain about the food. They may complain that the doctor is too busy to see them as often as he used to, that there aren't enough floor nurses. A few ward patients dislike being placed in the same room with eleven others and treated as instruction material. But these complaints, whether valid or invalid, apply to all hospitals. And most of them are relatively unimportant.

Complaints about the clinic have a more substantial basis. The method of selection is puzzling to those who are rejected. A good many people do not understand why such a big place cannot take in everyone. Patients often have to wait long hours on hard benches. There is a certain institutional herding and an occasional curtness, perhaps inevitable.

ECONOMICS, SERVICE

Should such an institution be

even larger—to make room for those it must now reject? Or smaller—so that it could give more personal attention to fewer people?

Big hospitals like Presbyterian have a much higher cost per patient-day than small hospitals. The 1942 average for general hospitals in New York City was $7.21. The most economical were those of 200 to 500 beds, with costs running about $6 a day. Presbyterian's $10.28 per patient-day cost was the highest in New York except for Memorial (cancer) Hospital's $10.47; its per patient-day income was about average, $6.75. If it weren't for endowments and donations the hospital would soon close its doors.

The real question, however, is not of economy but of medical value. And the answer to that is harder. Staff physicians and surgeons are men of high standing. They do good work, and most of them say they can do it better at the center than they could at smaller institutions. Some outsiders disagree. The violent iconoclasts describe patients at the center as machines on a conveyer belt with a different mechanic fitting each cog and rivet and no one caring what happens to the whole; the heads of departments, they say, are not physicians but executives sitting in plush-and-mahogany offices; individual responsibilitity is lost and and most consultations mean passing the buck to the next man. The milder critics among medical men put their objections on grounds of distaste for anything so big; they prefer to work in smaller hospitals.

But patients at the medical center, even in the clinic where they are run through at the rate of 1,100 a day, do get individual attention and careful diagnosis, although it is true that the doctors lack time to become familiar with their personal and family backgrounds.

Each doctor is constantly under the watchful eyes of other men and women in his department and of the students he teaches. "The professor cannot teach mistakes," says Dr. George Cahill, director of the urological service. "The operation has got to be good when fifty eyes are on the surgeon. The good old general practitioner probably made more undetected mistakes in a week than a medical center doctor makes in a year."

LOOKING AHEAD

There still remain the reasonable questions of whether the medical center is too big and whether it is doing as good a job as it is possible to do. Columbia-Presbyterian is answering the first question by its postwar plans to add more services.

The City of New York will complete a cancer institute on medical center ground as soon as steel and labor are obtainable, and Presbyterian will build at least 200 low-cost private rooms, a contagious-disease unit, and an orthopedic hospital.

In a number of cities and rural areas today the trend seems to be toward integrated local services with a hospital as the focal point. It seems likely that after the war attempts will be made by state and Federal governments — unless the American Hospital Association and the American Medical Association get there first—to evaluate the health needs of every section of the country and to plan community medical services around central hospitals. Columbia-Presbyterian has helped to set the stage.

What About Security Values in the Post-Invasion Period?

Market believed basically sound from the long-term viewpoint

Investors—most of them invasion-conscious—were trying hard last month to gauge potential market action: Would securities respond to the invasion in terms of the long-range, bullish future? Or would their prices reflect only the temporarily bearish earnings expected to follow victory on the battlefields?

The answer depended upon what types of securities were being considered. Stocks in the consumer-goods category had—to a certain degree—discounted the invasion's effect. But capital-goods issues had not.

Analysis revealed the reason: Most companies in the consumer-goods field were not faced with a plant reconversion problem in the event of sudden victory; durable-goods industry was.

Typical of the common stocks which had already shown a bullish tendency before the Allies landed on French soil were such consumer-goods issues as Sears-Roebuck, Penney, Coca-Cola. The steels and rails, on the other hand, were examples of stocks that had not advanced noticeably, in fact, might even report lower earnings during the reconversion period. In other words, although victory is fundamentally bullish, a successful invasion was expected to have a temporarily depressing effect on the earnings of capital-goods issues.

For this reason, physician-investors who were willing to take a business man's risk were being advised last month to keep about 25 per cent of their funds in cash and high grade bonds, and to put the remainder into common stocks and lower grade bonds. (With the cash reserve, they could take advantage of any drop in prices that might come in the post-invasion period.)

The physician looking ahead more to his future retirement was told to pursue a more conservative policy: keep 50 per cent of his money in high-grade bonds and cash. Then, if the market should break, he could add to his common-stock holdings. Individual circumstances, of course, were to be considered – but in a broad sense, this sounded like a wise course to well-informed investment counsel.

Reconversion, it is estimated, can be completed in four to eight months in most industries, once management

This article was prepared in collaboration with the Arnold Bernhard, well-known New York investment advisor (registered with the Securities and Exchange Commission).

has the go-ahead; but there are other interim considerations which must not be overlooked in gauging future trends:

¶ Many raw materials will not be immediately available even after a European victory. Until the war in the Pacific is concluded, the War Production Board may require automobile companies (and others) to stand by—to be ready to resume munitions-making in the event of an increased demand for materiel in the Pacific theater of operations.

¶ Demobilization of manpower from the Army to civilian production will take time, as will the retooling process in industry. The resulting period of temporary unemployment will cause the national income to decline.

¶ Congress must rescind the present excess-profits tax before company earnings can reach their hoped-for postwar levels.

With these conditions out of the way, it is believed that the national income in the first postwar year should hit a figure somewhere between 100 and 135 billion dollars—much less than the present level but considerably higher than the prewar mark. But even then, per-share earnings of many corporations should be substantially greater than they have been in all-out war production.

Listed as good long-term possibilities when the invasion began were stocks in these general classifications: steels, rails, aircraft manufacturing, auto accessories, machinery, and building construction. This, of course, was only a generalization, for the list might well have included, for instance, a number of automotive-manufacturing and retail-trade issues.

None can say what the market's sentimental reaction will be when a dramatic military event takes place. So far in this war, whenever our forces have been victorious, stocks have tended to rise, indicating that the market recognizes victory as basically bullish. From time to time, however, as the invasion armies surge forward or are thrust back, prices will wobble.

But they won't collapse, investment experts were convinced in mid-month. Fundamentally, they said, the investment market is sound.

—NORMAN NASH

Holding Out

I was preparing a hypo for a woman who had severe cramps. The husband asked if he might hold his wife's hands while I gave the injection. Since he said it would comfort her, I saw no objection and told him to go ahead.

When I was ready to leave and was waiting for my fee, the husband, still holding the patient's hands, turned to me and said: "I always pay my bills, Doctor, but at the moment, you see, my hands are tied."

Inasmuch as I never got a dime out of him, I now discourage hand-holding before I collect.

—I. LAUFMAN, M.D.

What Kind of Statement Do YOU Send Out?

Physicians disagree widely over form and content

Most physicians employ a statement form that is short and to the point. At least that is indicated by examination of a large number assembled by MEDICAL ECONOMICS (some representative forms are shown in the two following pages). As a matter of fact, many statements carry only the doctor's name and address and a variation of the phase, "For professional services rendered."

A great many practitioners neglect to include such information as phone number, specialty, and office hours—apparently forgetting that a patient occasionally uses a statement as a "card" in recommending his doctor to a friend.

On the other hand, "footnotes" are common enough, and range from the rather obvious phrase, "Your check is your receipt," to the more useful one, "An itemized statement will be mailed on request."

Doctors are still divided on the advisability of including a brief fee schedule. The pro's assert that one is highly desirable when the bill is not itemized, since the patient will probably remember the services he has had and be able to verify the total. But the con's say that a fee schedule looks "mercenary" and invites a patient to criticize the physician's charges.

Opinion is also divided on the combination statement and envelope Some feel that its convenience impels the patient to write out and mail a check immediately. Others damn it as "cheap" and "undignified."

The familiar perforated billhead employed by public utilities and department stores bobs up here and there among the samples. It has the undeniable advantages of speeding the work of bookkeeping and of preventing errors stemming from illegible check signatures.

Special statement forms include those that are a part of a professional bookkeeping system. One provides for the listing of individual charges, which are keyed with a printed code describing the nature of the service.

For mailing, it appears that both regular and window-type envelopes are popular.

Physicians generally seem to order a good quality paper (*e.g.*, 24-lb., rag-content white). There is little discernible tendency toward the use of tinted stock for its attention-getting value. Ink is almost invariably black.

On the whole, the printing quality of statements examined is good—comparing favorably with that available from printers who supply banks and financial institutions.

—D. A. GERARD

HARRY C. MESSINGER, M. D.
210 ANSELL STREET
PROVIDENCE, R. I.

DASPEX 3038

_____ 19____

$_____

_____

PLEASE RETURN THIS PART OF VOUCHER WITH PAYMENT.
NO RECEIPT WILL BE SENT UNLESS REQUESTED.

FOR PROFESSIONAL SERVICES

HARRY C. MESSINGER, M. D. PAID_____CHEQUE_____

E. MILTON STAUB, M. D.
521 EAST BROAD STREET
WESTFIELD, NEW JERSEY
PHONE WESTFIELD 3-3030

TO PROFESSIONAL SERVICES RENDERED

BALANCE
OFFICE CALLS AT $3
HOME CALLS AT $4
NIGHT CALLS AT $5
SUNDAYS AND HOLIDAYS AT $5
SPECIAL EXAMINATIONS
SPECIAL TREATMENTS
TELEPHONE CONSULTATIONS
LABORATORY EXAMINATIONS
BLOOD COUNT
URINALYSIS
OTHERS
MEDICATION
SURGERY

AS CANCELLED CHECK IS A RECEIPT, RECEIPTED BILLS WILL BE SENT ON REQUEST ONLY.

TO PROFESSIONAL SERVICES TO DATE

ITEMS MAY BE SEEN AT OFFICE

M. D.
STREE
YORK, N.

ALGONQUIN 4-0790

TO_____

FOR PROFESSIO

USE THIS ENVELOPE FOR REMITTANCE

WARREN E. SMITH, M. D.
MEDICAL BUILDING
KANSAS CITY, MISSOURI

IN ACCOUNT WITH

Mrs. Richard R. Mason
3623 Grand Avenue
Kansas City Missouri

DATE	SERVICE	CHARGE	OLD BALANCE / PAID	BALANCE
			OLD BALANCE	15.00
7/22/39	O. V.	2.00		17.00
7/25	O. V.	2.00		19.00
7/28	O. V.	2.00		21.00

O. V. OFFICE VISIT — SUR. SURGERY
H. V. HOME VISIT — OBS. OBSTETRICAL
N. C. NIGHT CALL — CON. CONSULTATION
HOSP. HOSPITAL CALL — SP. SPECIAL
LAB. LABORATORY — MED. MEDICINE

BALANCE DUE IS LAST AMOUNT IN BALANCE COLUMN

CAMDEN, MAINE, _____ 194__

IN ACCOUNT WITH

DR. J. SHERWOOD ARMSTRONG
E FREE STREET

OFFICE PHONE 3044 — REG. NO. 386

TO PROFESSIONAL SERVICES RENDERED

TO BILL RENDERED $

PAID ON ACCOUNT $

BALANCE DUE $

STATEMENTS RENDERED MONTHLY

RECEIVED PAYMENT _____

AN ITEMIZED ACCOUNT MAY BE SEEN AT MY OFFICE AT ANY TIME

XUM

AMA Attacks the Curtailed Production of Doctors

Says it endangers population and lowers professional standards

Severe criticism of Government policies concerning medical students was voiced last month by both the American Medical Association and the American Dental Association. Pointing to the fact that the War Department intended to accept a total of only 2,800 medical and dental students for the term beginning next January (instead of 5,800, as originally planned), the associations asserted that the curtailment would

¶ Drastically reduce the size of classes;

¶ Endanger civilians by further increasing the ratio of patients to physicians and dentists;

¶ Penalize medical and dental officers, who would remain in uniform while young 4-F's and women were permitted to build up practices;

¶ Possibly, in its wake, bring a lower quality of medical and dental care.

Of this year's medical-student crop, the Army accounted for 55 per cent; the Navy, 25 per cent. The remaining 20 per cent consisted of 4-F's and women. But for the next year the Army was planning on only 28 per cent of the total. Thus, unless the Navy increased its quota*, medical schools would either have to slash enrollments or find 4-F's and women to the extent of 47 per cent.

Dr. Victor Johnson, secretary of the AMA Council on Medical Education and Hospitals, says that of course there simply aren't enough 4-F's and women qualified or willing to study medicine to keep class enrollment at the 1944 level. Dr. Fred Zapffe, secretary of the Association of American Medical Colleges, thinks some of the larger, more popular medical schools might be able to get enough rejects and women, but wouldn't accept them. The ADA feels that loading classes with these people might involve the acceptance of less desirable students —producing in the long run, less competent practitioners. Consensus was that medical and dental freshman classes in 1945 would be about two-thirds the size of this year's.

The Army's decision to take fewer students was prompted by two factors: (1) It had overestimated its required number of medical officers; and (2) it badly needed fighting men in the 18-26 (medical-school age) group. The Navy, on the other hand, had underestimated the number of medical men it should have; so it decided to retain its quota next year, possibly even increase it.

Recently, the Procurement and Assignment Service, revealing that

*The Navy announced recently that it *might* raise its quota to 31 per cent, but didn't promise.

it had vainly sought to have the Army reverse its decision, said it regarded the situation for the future as grave. The P&AS estimated that of approximately 6,440 medical students entering classes in 1945, the Army would provide 1,790 and the Navy 1,540. This would leave 3,110 places to be filled by women and 4-F's. Some 500, it added, could probably be filled by women.

"Less than 10 per cent of present medical students are physically disqualified for military service. Liberalization of Selective Service classifications, and the discharge of increasing numbers of men by the Army and Navy, should make it possible to augment somewhat this proportion." Only time, it said, could demonstrate that.

The P&AS disclosed that it had taken these steps in seeking a reversal of the Army's new policy and a modification of Selective Service's non-deferment rule:

¶ Conferred with the surgeons general of the Army, Navy, and Public Health Service. "It was mutually agreed that the effect... would be dangerous in terms of production of physicians, continued existence of the medical schools, and the effects on public health."

¶ Had Paul V. McNutt transmit its objections (to the policy of non-deferment) to Maj. Gen. Lewis B. Hershey, director of Selective Service. General Hershey replied: "No exceptions will be made..."

¶ Had Mr. McNutt write the Secretaries of War and Navy, urging them to provide some status for a sufficient number of students to fill entering classes. The Secretaries jointly answered: "The immediate needs of the war for their services ought not to yield to the prospective use of them as doctors in 1949 or thereafter... The action of the director of Selective Service in refusing deferments was, therefore, in accord with the recommendations of the departments... To put these students into inactive status... would nullify the action of Selective Service..."

Although the AMA was apparently resigned to the fact that medical care for civilians would remain at a premium for the duration no matter what program was adopted, it argued that the Army's plan would aggravate an already tight situation by cutting the supply of new doctors at the source. That, said the AMA, would mean fewer physicians for the Army as well as for civilians.

The curtailed program might well give young graduates an unfair advantage over their colleagues in uniform, the ADA felt. Assume, it said that medical and dental schools took a larger proportion of 4-F's and women; these people would, upon graduation, go straight into civilian practice, at the expense of medical officers. The association pointed out that while the war will probably end before 1945 freshmen graduate, no one knows how many officers will be retained by the services afterward—or for how long.

The AMA urged the War Department to reconsider, asserting that there was a satisfactory alternative to its slash; the program that had been in operation for about twelve months and had worked well until it was dropped by the Army about a year ago. Were it to reinstall this system, the Army would induct prospective medical students as privates and immediately assign them on inactive status to medical schools. Students would finance their own

education and wear civilian clothes. Thus, said the AMA, an adequate supply of medical students could be assured, yet the Army would be relieved of both expense and responsibility. If the Army found, say two years hence, that it required no more medical officers, it would not have to change students' inactive status.

But the War Department considered this arrangement merely a nullification of its decision.

Still another suggestion was advanced: that the Army select soldiers in service for a year or two, give them honorable discharges, and send them to medical schools. The AMA regarded this expedient as unrealistic.

Observers weighed the possibility that the Selective Service System might even yet grant deferments to students. But the AMA would not count on that—unless Congress or the President intervened. To begin with, Selective Service had already turned thumbs down on the proposal and wasn't likely to change its mind. The AMA's own distaste was based on a short period of medical school experience, when it was found that deferred students were profoundly unhappy because they felt they had no role in the war effort.

The Association of American Medical Colleges objected less strongly to the War Department's program. Dr. Zapffe's was a watch-and-wait attitude. He believed it impossible to form any opinion about what might happen to medical education in 1945 because the Army could revise its plans at any moment and probably would. In any event, he said, students admitted next January wouldn't be ready for practice until September 1948; by that time the war would probably be over and enough medical officers would have been demobilized to satisfy civilian requirements. In the interim, he added, a lot could happen.

According to Dr. Johnson, however, if the Army program as it stood last month should go into effect next January, at least one thing would be predictable: He believed that the decline in student enrollment would cause medical schools to return to the policy of annual admissions (instead of accepting students every nine months as in the current program). This did not, he said, imply that the accelerated program would be abandoned; students would still complete their training in three years and their interneships in nine months.

—GEORGE B. FRITZ

Pay-off

My first office adjoined that of a chiropractor. For days I had awaited my first patient—but nobody came. Hence, when an old man showed up one morning and asked if I was "the doctor who rubs people's backs to get the kinks out," I lost no time getting him into my treatment room. There I proceeded to give him the best damned chiropractic adjustment he'd ever had! He said he felt much better, and I suggested that he come back every day for a week; which, lo and behold, he did! He gladly paid me two dollars for each visit—my first earnings as a physician.

—M. H. CARRIG, M.D

California Survey Indicates Social Medicine Favored

State association urged to offset trend by constructive action

"The people of California are overwhelmingly in favor of Federal medicine, but physicians can still turn the tide." This, in effect, was the verdict of a nationally known advertising and public relations counsel, after a state-wide survey made for the California Medical Association.

The council of the CMA, which has been devoting considerable attention to public relations and legislative problems, engaged Foote, Cone & Belding (formerly Lord & Thomas) to measure public opinion in California. Results of the study, together with the agency's interpretive report, include some striking data on federalized medicine as viewed by Californians.

Using trained investigators, the agency obtained 5,090 personal interviews representing a broad cross-section of the state's population. Although many of the findings dealt with other economic aspects of medicine,* those relating to Government control were the most important.

The following quotations are taken from the summary of the survey:

"Do you think we should have some sort of socialized government-controlled medical plan?

"Fifty per cent of the people interviewed said we should; 34 per cent said we should not. Sixteen per cent said they did not know. People in the lower brackets are generally more in favor of socialized medicine than those in the upper brackets.

"The main reason given for thinking we should have some sort of socialized government-controlled medical plan was that it would provide medical care for the poor. Ten per cent think it would lower prices; 12 per cent think it would raise the standard of public health.

"The main reason people are against government-controlled medicine is that they are against government control generally. This feeling is greater in the upper brackets than in the lower brackets, among men more than among women, in the older groups more than in the younger.

"Twelve per cent think that socialized medicine would be discriminating against the doctor; that he should have the same rights as other professional men. Ten per cent think it would attack personal freedom.

"If you were asked to choose between one of these plans for medical care which would you prefer?

"Thirty-five per cent of the people interviewed chose our present system of private practice, 31 per

*To be reported in a later issue.

per cent chose the California Physicians' Service plan, 23 per cent chose socialized medicine, and 4 per cent chose the clinic system."

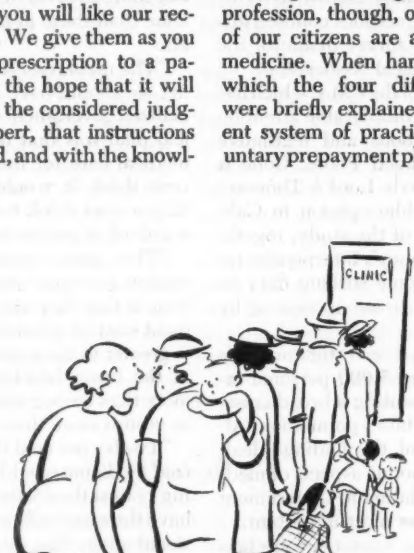
In a report to the association, Foote, Cone & Belding offered the following interpretive comment (condensed):

"This report contains the considered opinion of a 24-man board of public opinion specialists. We have chosen to confine ourselves to the one major issue: Federal medicine. We want to direct your full attention to it, to show you what you *must* do to meet this threat. We do not delude ourselves that you will like our recommendations. We give them as you would give a prescription to a patient, *i.e.*, with the hope that it will be accepted as the considered judgment of an expert, that instructions will be followed, and with the knowledge that if they are, relief may be expected logically to follow.

"One of the heart-warming elements of the survey is the high opinion in which most citizens hold the profession of medicine. It is because of this high opinion that we can say that the medical profession, as such, has no desperate public relations problem.

"Eighty per cent of the citizens would advise young men to study for medicine. Eighty-eight per cent think the majority of doctors are doing a good job for the public. This is an amazing index of approval.

"Despite this high opinion of the profession, though, only 34 per cent of our citizens are against Federal medicine. When handed a card on which the four different systems were briefly explained (1. The present system of practice. 2. The voluntary prepayment plan. 3. The med-



ical center plan. 4. Federal medicine) only 35 per cent chose the present system of private practice.

"What does this mean in terms of politics? Simply that 50 per cent of the citizens are definitely in favor of Federal medicine; that 34 per cent are against it; and that 16 per cent haven't as yet made up their minds. If it were to come up on the ballot today, you could have only 34 per cent of the votes. You would have to swing to your side *all* the 16 per cent who haven't yet made up their minds—an impossible task. And even if you *could* swing all the 16 per cent, you still wouldn't have a majority. To us it seems abundantly clear that you would lose the issue—perhaps by a landslide.

"This conclusion becomes even clearer when you analyze the disposition of the votes:

"1. Approximately 50 per cent of the votes in each of your association districts are for Federal medicine.

"2. All income classes show phenomenal percentages for Federal medicine: 36 per cent of the top, or A, income group; 42 per cent of the B group; 51 per cent of the C group; 52 per cent of the D group; and 56 per cent of the lowest income group.

"3. All occupations, from professional to unskilled labor, show percentages ranging from 44 per cent to 56 per cent in favor of Federal medicine.

"4. Nor are there important differences according to city-size, though rural is slightly more for Federal medicine than urban.

"5. And men are only slightly stronger for Federal medicine than women: men 54 per cent; women 46 per cent.

"This should be enough to show you that the opinion is *not* spotty. If it were, the solution would be easier. But the opinion is *general.*

"Since California is at the top among states in standards of living, you can apply these percentages to the nation as a whole *and be conservative!* [Doubtful conclusion.—ED.]

"Let's carry this a little further and ask ourselves: Why is there such a desire for Federal medicine when there is such high approval of M.D.'s? The survey gives and proves the answer: People believe that the cost of scientific medicine is too high.

"Here are a few facts:

"1. Among the 88 per cent of the people interviewed who think the majority of doctors are doing a good job, 10 per cent added the voluntary comment that *some* are charging too much.

"2. Among those who think M.D.'s are not doing a good job, 38 per cent* said it was because they overcharge.

"3. Among the 36 per cent* who think doctors are dishonest, 31 per cent* think that they are dishonest as to cost. An additional 17 per cent* think they prescribe too many unnecessary treatments and expenses. This is merely another way of balking at costs.

"4. Overcharging was chief among their pet peeves. (The pet peeves are surprisingly small, but 10 per cent listed overcharging, which is certainly an index.)

"5. Among all those throughout the state who want Federal medicine, *cost* is the basic reason for their choice. Thirty-eight per cent say they want Federal medicine because it would provide for the poor. This is another way of saying that medicine

*N.B. This is a percentage of only the 8 per cent who think doctors are *not* doing a good job. It is not a percentage of the total number interviewed.

is too dear for the poor. Thirteen per cent say it would be beneficial to the people. This is another way of saying: cost. Ten per cent state simply that it would lower cost. And 12 per cent think it would raise the standards of public health. They mean that scientific medicine would be available to all, whereas now it is not available to all because of cost factors, and the standard of public health is therefore lower. So far this totals 72 per cent. If you will examine the other reasons listed, you will get the distinct impression that cost is practically the whole reason.

"All this is just a fraction of the evidence that Federal medicine is being nurtured by the seemingly high cost of private medicine today. Furthermore, it is not only the cost of the doctor which irks people, but hospital charges, nurses' fees, prescriptions, and other costs.

"Among the upper income groups, Federal medicine is desired because of the poor. Among the poor, it is desired because they themselves want proper care.

"You may be able to refute each of these opinions held by the public, but it will do you no good. Why?

"1. Because they cannot hear your argument.

"2. If they could, they would merely point to those spots where scientific medicine is not available to certain segments of the population, and further argument would be ruled out.

"3. You would be strictly on the defensive. To win a defensive argument in public debate is a difficult matter—as Dr. Fishbein is currently discovering.

"So far in our thinking, it hasn't seemed wise to go to the public with a defensive story. As we study and learn more we may, perhaps, change our minds.

"At this point, you should be asking yourself the question: 'Why is medicine singled out? Hasn't the doctor as much right to the advantages of free enterprise as anyone else?'

"The public doesn't think so. The public is applying to the profession a principle as old as this nation. When something is desperately needed by all the people, but only part of the people can obtain it because of cost—then it must be socialized so that all may have it.

"The people quite evidently think that medicine should be a public utility under Government control and operation—like the postal system.

"Once you recognize this principle, the solution is immediately apparent:

"*To save free enterprise in medicine, it is necessary to provide scientific medicine through free enterprise in a manner which will make it readily and economically available to all of the people all of the time.*

"The citizen selects Federal medicine *only* because he thinks he can get scientific medicine *no other way*. He has a tremendous desire for the advantages he thinks are available only through private practice, which is too dear. Ask him what he *wants* as against what he thinks he can get—and you will find he wants (1) security; (2) his bills taken care of in advance; (3) to be prepared in case of emergency; (4) the assurance that all his fellows are also being taken care of; (5) the right to choose his own doctor.

"He wants all this *provided* (and this is the catch) *he can get them at a low enough cost.*

"We recommend that the Califor-

nia Medical Association recognize the fact that Federal medicine has swollen into a tide which is sweeping the public before it; that the association make no attempt to obstruct this tide defensively; that rather, it admit the factors which produced Federal medicine and prepare itself to ride them; that it do this by using a prepayment medical plan set up by the medical profession and developed along the best lines so that it can function as a substitute for Federal medicine; and that in this manner it wean away from Federal medicine the majority of the electorate.

"You already have a prepayment plan—the California Physicians' Service. One of the questions puzzling us is: Why hasn't CPS gone further than it has? It is a very salable product. It has been in existence for a

"The poor ones can't pay and the rich get insulted if you mention money."

number of years. It has given more in service than the dollars it has received. Yet only a miserable percentage of the people ever heard of it.

"The whole concept of CPS is masterful. But your failure to promote it with an expertly designed and constructed plan is nothing less than tragic. It is tragic because by this time CPS should be flourishing, should have become the focus of national medical attention. It could have long since served as a model for other state medical associations. And had it done so, the issue of Federal medicine might well not be confronting us.

"Now there is the Murray-Wagner-Dingell Bill. The President is said to be backing this bill. The President only moves on independently initiated bills when the polls prove he should. As of last fall, the polls showed that 59 per cent of the people nationally were for Federal medicine, and that only 29 per cent were against it.

"If CPS is to be made the answer, the profession *must* gather it to its bosom—and this leads to our second recommendation:

"We recommend that the California Medical Association refine California Physicians' Service so that it will be more acceptable to the general membership; that this be done without increasing the rate to the subscriber, which should be reduced if anything; and that upon points which cannot be compromised the membership be persuaded to accept the sacrifices necessary.

"Recommendation Number 3:

"We recommend that a campaign of education on CPS be instituted immediately among the membership of that association; that it be induced to become sympathetic to the methods used and the reasons for their use; and above all, that it be educated to the principle that a subscriber to CPS deserves all the consideration given to a private practice patient and that any discrimination is simply an invitation to him to embrace Federal medicine.

"We have had testimony that CPS subscribers *are* discriminated against in doctors' offices. This must be stopped. The only way to stop it is to prove to all the members the dangers inherent in any such practice.

"In the last analysis, if all association members are sold on CPS—if it is *their* baby, if they are proud of it and are eager to make it grow and thrive—then, and *only* then, can it be widely sold.

"It is also axiomatic that all CPS subscribers must be continually convinced they have made a good buy. Only the doctor can keep the subscriber sold on the plan. *It is solely his responsibility.* He does not now seem to be acquainted with this fact. Hence, the need for an educational campaign among the membership.

"To conclude: We are conscious of many other factors. We know that a large percentage of physicians of this state are in the armed services. In general, these are the younger men who ordinarily would be chosen to carry out this fight. Most of you who remain are older men. You undoubtedly feel you have already done your share of battling.

"Perhaps you cannot help thinking that this is a mighty bad time for a fight. And you are right—it is.

"But if the fight isn't made, the battle is lost. So far as we can see, there is no other hope on the horizon. There is at this time no national leadership seemingly competent to win through."

Financial Assistance for the Demobilized Physician

Coast association's program also provides for dependents

Last year a young Long Beach, Cal., physician was killed in action while serving with the armed forces. Not long out of interneship when he entered the service, he left his widow and two small children practically no cash assets. Worse than that, there were a number of debts against the estate—including a home mortgage and an obligation to a student-aid fund—that would consume most of the insurance proceeds.

Fortunately, the community had an organization prepared to meet just such an emergency: the Long Beach Physicians Aid Association, a nonprofit corporation formed early last year by a number of the city's doctors. While these men are concerned primarily about the financial problems of demobilized physicians, they are also ready to assist in solving the interim difficulties of dependents.

When the young widow's plight became known, a special fund was established; contributions ranged from $5 to $200. The $3,600 mortgage was liquidated, and when officials of the student-aid fund learned the facts they immediately cancelled the entire indebtedness of $500. Shortly afterward the widow was provided with a congenial position in a physician's office.

Members of the association contribute regularly to a postwar fund, in amounts ranging up to $100 monthly. So far, more than $14,000 has been collected and invested in war bonds, and it is expected that the fund will reach $20,000 by year's end. All of it will be held in trust until demobilization, and devoted then to the assistance of returning physicians. Until that time no definite program will be formulated, since members believe that service physicians should participate in its planning. Some of them will probably need financial assistance in reestablishing practices. Others will want money to take refresher or postgraduate courses. A few, because of disabilities, may not be able to resume practice at all. To such men the association hopes to extend all possible aid.

The association was set up as an independent, non-profit corporation because its sponsors felt that a similar program under the aegis of the county society might involve organizational difficulties, and also put on the spot those members who were already contributing generously to the assistance of friends and former associates.

Not all contributions came from within the profession; one layman was so impressed that he gave $500 to the fund. —A. T. ROBBINS

The Simplified Tax As It Affects Physicians

New law governs your return on 1944 earnings

Federal income tax simplification begins with your choice of the form you will file. If your total income (irrespective of source) less professional expenses is below $5,000, you may use a simplified return, taking a flat 10 per cent allowance for deductions. If such income is $5,000 or more, you must use a long form, which allows you a flat $500 for deductions if you wish to avoid listing them in detail.

Rates, though changed in name, remain essentially the same. However, the Individual Income Tax Act of 1944 has made noteworthy changes not only in deductions, but also in credits for personal exemption and dependents. Hence, the amount of your tax for 1944 will probably differ from the amount in 1943.

As signed by the President on May 29, the new law will simplify your return in the following major ways:

Normal tax. A new levy of 3 per cent on net income replaces the Victory tax. You may deduct a $500 personal exemption before computing the tax, and your wife's income (if any) is likewise exempt up to $500 on a joint return. No credit for dependents is allowed in figuring the normal tax.

Surtax. This starts at 20 per cent of the first $2,000, and scales up to 91 per cent of all income above $200,000. It is roughly equivalent to the old surtax plus the old normal tax. Before computing the new surtax, you take a simple credit of $500 for yourself, $500 for you wife, and $500 for each dependent. This eliminates the complicated set of personal exemptions formerly in effect, substituting a uniform exemption of $500 per person (*e.g.*, $2,500 for a husband with wife and three children).

Dependents. The new legislation not only boosts the allowance for dependents to $500 each, but also redefines dependents on a more generous basis. The term "dependent" ceases to be limited to children under eighteen and adults unable to support themselves. It now includes anyone related to the taxpayer in a degree specified (liberally) in the act, whose annual income is below $500. A child with an income above $500 ceases to be a dependent for tax purposes and must file a return of his own.

Deductions. If you fill out the long form, you'll find that deductions allowed are generally about the same as they were last year. The limit on charitable contributions is somewhat higher than before, but the limit on medical expenses is

lower (significant as affecting patients' returns.)

You may discover that the new measure has upset your 1944 estimates. But don't worry. These estimates were governed by the law in effect when you made them. There's no fine for under-guessing, provided you were within the legally allowed margin of error (20 per cent) at that time.

New provisions in the act which will affect withholding rates apply only to wages and salaries paid on or after Jan. 1, 1945.

—J. B. THURLOW

"Now don't try to fool me, doctor. I have a son in medical school."

'Why, It's Doctor Gamble!'

Radio's famous two-patient "physician" tells how he keeps Fibber McGee in hand

American medical men have been writing me for months, clearly envious of a doctor who, be he ever so phony, can tell off his patients and get away with it.

Yes, sir, ever since I began putting that pudgy little potato patty, Fibber McGee, on the frying pan every Tuesday night, I, Dr. J. Ramsey Gamble, have been looked upon with green eyes by many a doctor who gives an exasperating patient a placebo but longs to substitute a Mickey Finn.

I have learned a great deal since I became McGee's physician, and I assure you he's a very difficult man to learn anything from. Or to get money from. He thinks money carries disease, and who'd be contemptible enough to hand a doctor a lot of germs?

Well, I have frequently—and in no uncertain terms—told McGee the only thing that keeps me going after twenty years of practice is curiosity. I can never wait to see what kind of stupidity the so-called human race is going to exhibit next. But even *I* get fed up.

"McGee," I told him once, "if you ever break your leg, call in a tailor. Maybe he can press your pants so it won't show."

Well, hypo my dermic, but that little spatula stealer got nasty.

"Listen," he says. "You claim to be a doctor. Maybe so. All I know is that when you performed an appendectomy on me I could hardly see the scar. That is—provided I kept my coat collar turned up and my trousers cuffs turned down.

"Furthermore," yells Fibber, "you've been charging me for treatments when there was nothing the matter with me. I'm gonna report you to the American Medical Association for malnutrition!"

"You mean malpractice, McGee. You could never get me on malnutrition!"

"Why couldn't he?" Fibber's wife, Molly, wants to know.

"Because I'm fed up!"

Of course, Fibber isn't always the hypochondriac. I recall the day I dropped in on him and Molly, just to take a load off my metatarsals. McGee proceeded to tell me he was the fittest man in town, because he'd been living for a week on a health diet of raw rhubarb and bird gravel.

"You're the most gullible guy I ever met," I told him. "Why don't you bequeath your brain to science? On second thought, no; even the electronic microscope isn't that powerful."

So Mrs. McGee wanted to know if all doctors were so cynical.

"Cynical my clavicle," I said. "I'm a bright-eyed optimist. Why, I even have a childish faith that some time

I'll meet a human being who doesn't think his hangnails are the medical sensation of the century."

Well, at 7 o'clock next morning Molly phoned me that McGee had swallowed a safety pin. The human scrap pile stood near the telephone groaning pathetically while she talked. And when I arrived, he was in the middle of the loudest case of unconsciousness I ever heard.

"Do you think he really swallowed a pin?" Mrs. McGee wanted to know.

"I hope so," I said.

Then I told her about my new invention for extracting swallowed objects. The Gamble Grab, I called it. I had been buying marbles for the little boys in the neighborhood all spring, but nothing had happened yet and here was a golden opportunity staring me straight in the face.

An X-ray would have shown the pin, of course, but that would have taken all the fun out of guessing. So I made McGee take off his pants.

"I didn't sit on it," he yelped, "I swallowed it."

Well, that disagreeable little nature faker had dropped the pin in the cuff of his pants, as I presumed in the first place. So I charged him $7 for a house call—just to see his blood pressure go up beyond the OPA ceiling—and walked out on him.

This last spring, when Mrs. McGee started housecleaning, McGee claimed he was ill again. He had alphabetical symptoms, he told her. "A," he was all worn out; "B," he was bushed; "C," he had chills; "D," he was debilitated "E," he had no

"This business used to slay 'em in vaudeville!" McGee, Dr. Gamble, Molly

energy; and "F," he needed a physician. He wanted Molly to invite me over for dinner, so he could get some free advice.

He had a feeling of lassitude, he told me when I arrived. His longitude wasn't so hot either, except when he stretched it out on the couch.

"I bet I got the collie," he moaned.

"You mean the colic."

"I don't either. A colic is when your hair won't stay down."

"That's a cowlick," Molly said.

"I thought a cowlick was a big hunk of salt they put in a pasture."

"Maybe it is," Molly came back, "but you don't mean a collie. A collie is a dog."

"That's what I says," says McGee. "I'm dog-tired."

I listened patiently. The only reason I'd come was because I wanted to avoid a lecture on "The Evolution of Bone Structure in the Lesser Mammals" by a guy who knows so little about bones you could bury them all in a flowerpot.

And there was McGee, the picture of health, relaxing on the davenport. But he had more symptoms than Heinz has varieties. Finally he wound them up: "I got no energy. I got no pep. Ever since I got up this morning I been feeling dopey. I—"

"McGee," I yelled, "you've just diagnosed your own case better than a whole staff of specialists."

"You mean I'm just naturally a doctor?" he asked.

"No," I told him, "you're just naturally a dope."

And that, fellow physicians, is the way I handle my prize patient, Fibber McGee. But he always comes back for more.—J. RAMSEY GAMBLE

"Looks like pulling me through is going to be quite a credit to you, doctor! I received your bill today."

Senator Pepper in Pascagoula

Medical care in a warboom town gets a Congressional investigation

"Pascagoula was chosen for the first field hearing because it is a typical, crowded war community and therefore its problems will be indicative of the state of wartime health in the entire nation."

Thus spoke Senator Claude Pepper (D., Fla.), chairman of the Senate's subcommittee on wartime health and education. With a staff of investigators, he had come down to Jackson County, Miss., whose Gulf coast town of Pascagoula, normally a rural trading center of about 4,000, was now swarming with shipyard workers and their families—some 30,000 people in all. The Senator hoped to recommend Federal action if his field studies showed that medical facilities were inadequate.

But the Pascagoula investigation brought forth no unusual statistical data. It proved interesting mainly because of the conflicting opinions it elicited. Medical facilities were adequate or inadequate, depending upon whom the Senator queried—and he queried nearly everybody: the ship-building company; organized labor; private physicians; the Maritime Commission representative; local, state, and Federal health authorities; the Governor; the mayor; Federal housing officials; ministers; teachers; housewives; hospital executives; dentists; welfare workers; and a lot more.

Jackson County, the Senator was informed, had one hospital (its reported capacity varying from seventy to 100 beds), a twelve-bed infirmary, twelve private physicians, an estimated population of 50,000. The ship-building company maintained a yard clinic, three first-aid stations; employed four full-time physicians and twelve nurses to care for 12,754 workers. The county health department's staff consisted of one physician, five nurses. Such, approximately, were the facilities and personnel. How adequate were they?

Wholly inadequate, said labor officials; there was delay at the yard in treating injuries, patients had to "wait hours at doctors' offices," a new 100-bed hospital was needed, prescriptions cost too much, the state had no workmen's compensation law; and so on.

The shipbuilding company also thought the situation was pretty bad—outside its own yard. The town needed this and that: better maternal and child care, outpatient clinics, a community nursing service, more doctors, dentists, hospital beds. The hospital should have a resident, should obtain an oxygen supply of its own and not be calling on the yard for oxygen. A check of sick absentees had shown that a great majority had been unable to secure the services of local physi-

In Anemia of PREGNANCY

THE prophylaxis and treatment of anemia of pregnancy poses a special problem because of the instability of the alimentary tract in gravid women. In the solution of this problem, the intrinsic advantages of colloidal iron over ionizable iron salts (sulphates, citrates, etc.) is of major significance. In the stomach, the iron salts ionize into iron and acidic ions likely to be astringent and irritating. This is true regardless of whether the salts are in pure form, in masked solution or in coated tablets. In the alkaline intestine, the salts form precipitates which are dehydrating, constipating, and not easily assimilated.

But these things *cannot* happen with OVOFERRIN, for OVOFERRIN is *colloidal* iron. It is *not* in ionic form. It is *little* affected by the gastric juice. It remains stable and cannot irritate. It cannot constipate for it reaches the intestine as a fully hydrated colloid—a form in which nutriment is readily absorbed. For these reasons physicians have come to regard OVOFERRIN as the ideal hematinic in pregnancy. For these reasons also, OVOFERRIN has achieved a reputation as "The Rapid Blood Builder" in secondary anemia, convalescence, anemia of children, and run-down states. Its palatability and high assimilability assure patient co-operation and better results.

PRESCRIBE **OVOFERRIN**

COLLOIDAL IRON-PROTEIN BLOOD-BUILDER

In Secondary Anemia, Convalescence, Pregnancy, "The Pale Child," and Run Down States

A. C. BARNES COMPANY

NEW BRUNSWICK, N. J.

cians, had been forced to treat themselves with "aspirin and various other medicines." The company would welcome Federal intervention.

Said the concern's medical director, Dr. L. C. Spencer: "I have investigated and discovered that the relative cost of hospital care here is cheap, and I don't think the doctors charge an exorbitant price; but when you consider the general economic level it is still too high." A full course of treatments for syphilis, Dr. Spencer said, would be "prohibitive."

The Senator appeared to be getting nowhere fast; the deeper he dug into local affairs, the fewer facts of national significance he unearthed —and the more opinion he amassed.

But he kept delving.

Dr. James N. Lockard, representing private medicine, told the Senator that the twelve physicians in active practice in the county, plus the four shipyard doctors, were sufficient to care for "a population of 40,000." He admitted that three of his colleagues were over 65 years of age. Asked if local M.D.'s had more patient calls than they could take care of, Dr. Lockard replied, "We get to them, Senator. Sometimes it is a little late at night, but we get there if they will just wait long enough." He called the nursing situation "critical at times," with private-duty nursing almost impossible to obtain. Hospital facilities he considered adequate.

Help was needed on T.B. control, Dr. Lockard said; the state sanatorium had a waiting list. Child health was inadequate, but only because parents had not been properly educated—a duty for which state and local health authorities should be responsible.

The Senator wanted to know why V.D. indigents in Jackson County could not be treated by public health agencies unless referred there by private practitioners. Dr. Lockard explained that the profession has felt that such clinics should not be available to those who could pay.

Dr. Charles McGill, assistant chief consultant of the Maritime Commission, thought the shipyard's facilities adequate, admitted washroom conditions were otherwise, called general sanitation only "fair." Pre-employment examinations included no test for syphilis. There had been no photo-fluorographic survey for T.B. Typhoid immunization was available locally.

Had Dr. McGill made any requests

[*Continued on page* 68]

Murder by the Mortician

When a TB patient died in our hospital, a clerk was instructed to send the following telegram to the victim's parents: "Your daughter died this morning. As per arrangement with local undertaker, body will be shipped tomorrow."

The clerk phoned the message to the telegraph company, which apparently did a little re-punctuating—with the following result: "Your daughter died this morning as per arrangement with local undertaker. Body will be shipped tomorrow."

—HARRY H. BRAUER, M.D.

for assistance which had not been complied with? Yes, said the physician; he had been blocked by the local medical profession ("for their own reasons") in getting a V.D. control program started.

Asked about absenteeism due to illness, he estimated that 95 per cent of it was due to nonoccupational diseases, with respiratory ailments the chief cause. Local medical facilities were inadequate to deal with this situation, he concluded.

For three days Senator Pepper pumped question after question at witnesses from almost every walk of life; and every one saw reasons why this or that could or couldn't be done. Would more doctors help? One or two of the right kind might, conceded a hospital official, but "people are rather funny; they are not going to change doctors every so often; and in my opinion we couldn't get doctors to come here and make the change now anyway. I doubt seriously if anything much can be done about the situation until after the war."

At the end of the three days, the Senator had heard enough. To Pascagoulans he expressed his profuse thanks for their cooperation, adding vaguely that at some time in the future a local meeting might be called "to explore the possibilities of establishing something in the nature of a clinic which would enable the doctors, and possibly the dentists, to render more and better medical service to the people of the community."

Then, with a paternalistic promise that "the Federal Government has the power and the disposition to be of help to you," Senator Pepper and his retinue were off to Washington—bearing enough testimony to fill 448 printed pages. —MELVIN SCOTT

Typical Physician Ranks High In Professional Income

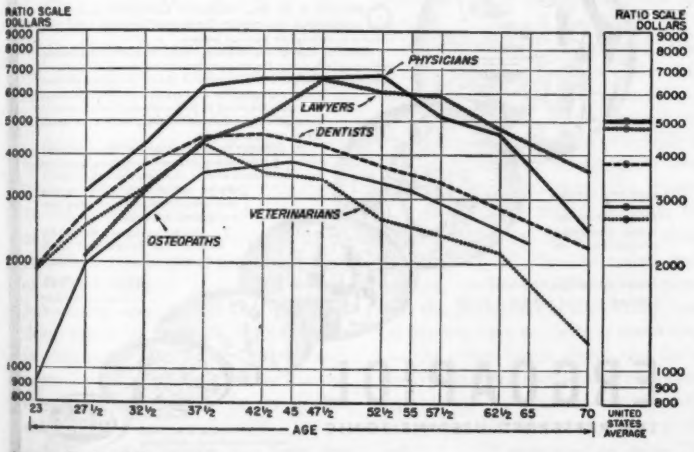
But earnings show less stability in changing economic conditions

Below age fifty-two, physicians earn more than lawyers. Above that age, lawyers earn more than physicians. At least that's the way it averaged in 1941, according to a report just issued by the U.S. Department of Commerce.

The department based its conclusion on a survey among men and women in non-salaried practice in five professions: medicine, law, dentistry, osteopathy, and veterinary medicine. (Its findings as to the range of physicians' incomes from 1929 to 1941, by size of city, age, and location, were published in MEDICAL ECONOMICS last December.)

In all years covered by the survey, physicians had substantially higher *median* net incomes than lawyers. Their *average* net incomes, however, were lower—except in 1941, when they spurted ahead (largely because the doctor shortage was then beginning to manifest it-

RANGE OF PROFESSIONAL NET INCOMES BY AGE, 1941



Source: Dept. of Commerce.

self, says the department). The survey also stresses the rather marked degree to which physicians' incomes fluctuate with the times; earnings of lawyers, private-duty nurses, and others, it says, are relatively more stable.

The chart on page 71 compares average 1941 incomes, by age groups, in the five professions already mentioned. The over-all average in each profession is shown in the vertical bar to the right. Physicians' net incomes, it will be noted, average slightly above $5,000; those of lawyers, slightly below.

The chart shows that physicians' incomes drop sharply soon after age fifty-two. Those of lawyers do not fall off much until five years later; and even then, they drop less; so that by the time the age of seventy is reached, there is a disparity of about $1,000 a year in the two professions.

The periods in which the five professions demonstrate their maximum earnings are quite different. Their peaks are as much as fifteen years apart. Thus:

Physicians	35 to 54
Lawyers	45 to 59
Dentists	35 to 49
Osteopaths	35 to 49
Veterinarians	35 to 39

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Medicine's Mounting Problem: Control of Mental Disease

Private practitioners expected to aid more in prevention

Statisticians have asked the question but as yet haven't found the answer: Is mental disease on the increase in the United States?

On first look, the figures appear to shout, "Yes!" Census Bureau records show that only 82 persons out of every 100,000 were in mental institutions in 1880. By 1900, the rate had jumped to 184; by 1923, to 245; and by 1942, to 453.

Startling as these figures seem, however, they are not conclusive. A number of factors have contributed to the increased rate of hospitalization:

Most important, of course, has been the expansion of mental hospital facilities. It has been shown that the greater the availability of an institution, the more willing a family is to commit one of its members.

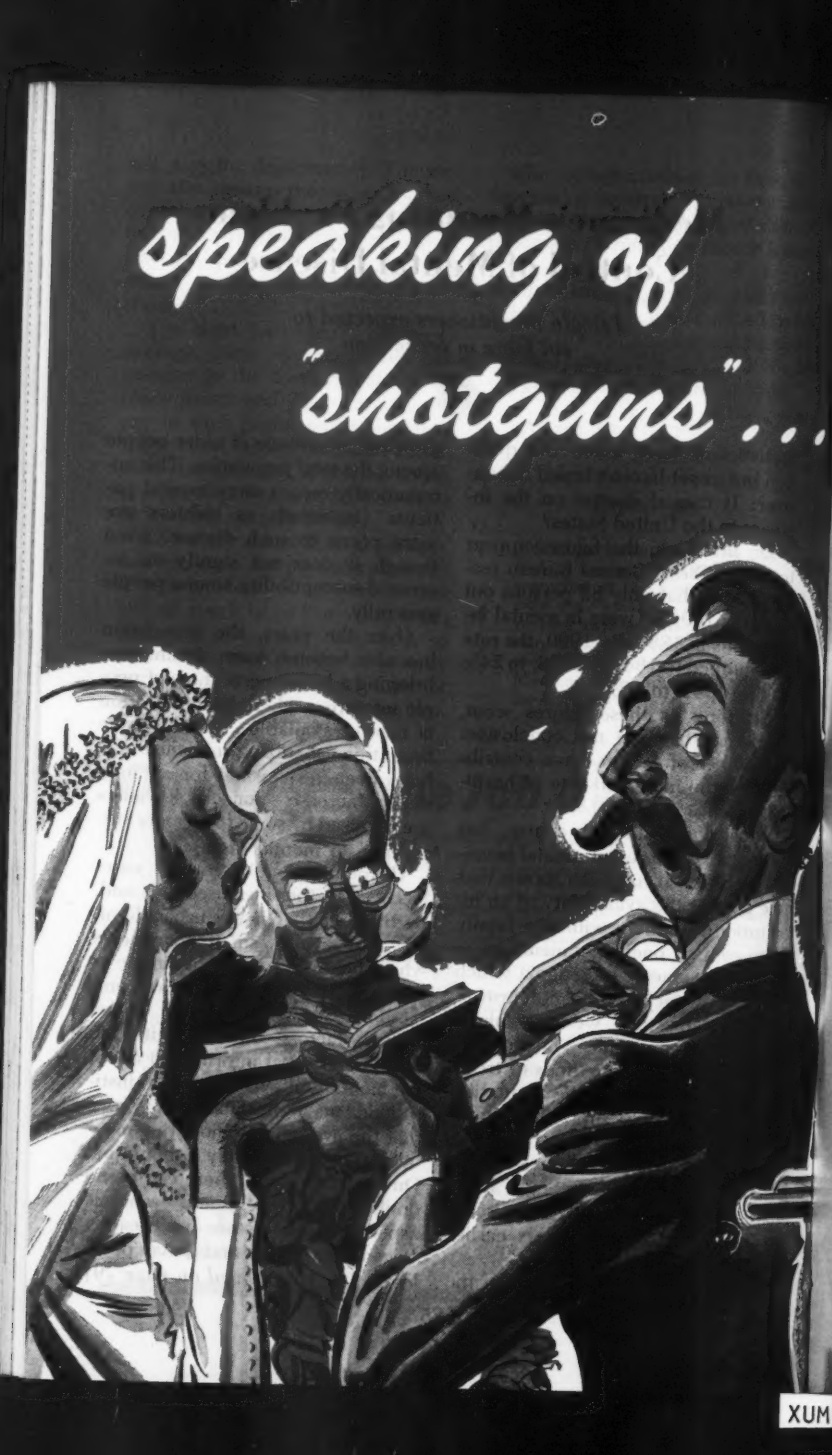
Again, some or the stigma which was once attached to mental institutions (when they were popularly called "insane asylums") has been removed. Improved methods of treatment have enhanced the reputation of many publicly supported establishments; and this, in turn, has done much to increase the hospitalization rate. Likewise, better diagnosis has played its part in discovering mental disease in its earlier stages.

Still another factor has been the growing percentage of older people among the total population. This automatically means more mental patients (inasmuch as oldsters are more prone to such disease) even though it does not signify an increased susceptibility among people generally.

Over the years, the population has also become more urbanized—bringing a larger percentage of people into areas where hospitalization is readily available. (At the same time, this urbanizing influence may have been responsible for an incidence increase—for city dwellers are believed by some to be more susceptible to mental disease.)

Hospitalization of mental cases has been further increased, it is said, by the fact that many urban families now live in small apartments where home care is not as simple as it was in the past when more commodious quarters were the vogue.

Such factors, together with the lack of statistical information about the mentally ill who are not in institutions, make it difficult to prove that the presumably mounting mental disease rate actually *is* mounting. On the other hand, there can be no doubt that the social and economic aspects of the disease are steadily becoming a greater and graver problem. [*Continued on page* 79]


speaking of
"shotguns"...

Surveys made by a leading insurance company a few years ago showed that mental and nervous disorders were the second most important cause of disability and that patients then in mental hospitals equalled the number in all other hospitals put together. More recently, a Public Health Service spokesman has stated that 58 per cent of all hospital beds in the country are occupied by mental patients.

The last official count indicates that public and private mental institutions are caring for close to 600,000 resident patients, plus an additional 80,000 on parole or in the care of their families. New cases are being admitted at the rate of 125,000 yearly. Discharges and deaths, however, make the net increase about 18,000 annually.

These figures were tabulated by the Census Bureau from individual reports of 633 institutions—including 260 state, 94 county and city, 27 federal, and 252 private hospitals and sanatoria. Not reporting were eight state supported institutions.

The present rate of admission means that one person in every twenty born will eventually be committed to a mental hospital. Government statisticians, using Massachusetts and New York records as a basis, have estimated that between 1,500,000 and 2,000,000 individuals in the country are mentally ill at the present time.

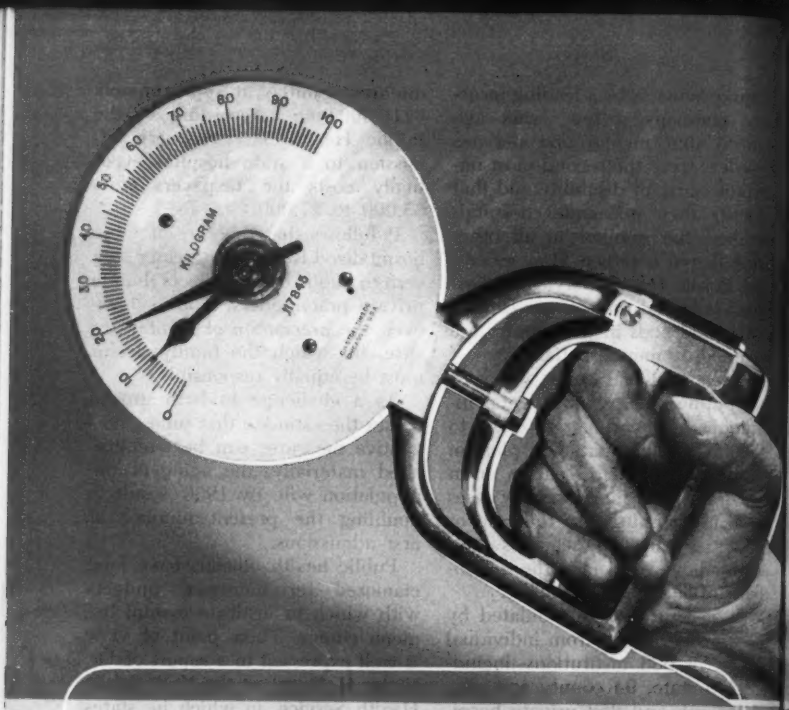
Of those now hospitalized, about 87 per cent are in state-supported institutions, with an additional 10.5 per cent in Federal, county, and city hospitals. Only 2.5 per cent are in private institutions. Thus, totally, 97.5 per cent are cared for with public funds – estimates placing the annual outlay at approximately $210,000,000. (According to the Public Health Service, every admission to a state hospital eventually costs the taxpayers from $5,000 to $7,000.)

It follows that the *care* of those hospitalized is of much greater concern to public health officers than to private practitioners. Not so, however, the *prevention* of mental disease, for which the family doctor must be equally responsible.

As a challenge to both groups comes the estimate that unless preventive measures can be strengthened materially, the aging of the population will, by 1960, result in doubling the present number of first admissions.

Public health officials have long clamored for increased budgets with which to institute mental hygiene clinics. Their point of view is well expressed in a report of Dr. Victor H. Vogel, of the U. S. Public Health Service, in which he states that "there are scarcely words available adequately to describe the almost total lack of effort being made to prevent mental illnesses from occurring or developing to the point where hospitalization is necessary."

Deploring the fact that the nation spends only about $5,000,000 annually on mental hygiene clinics, he goes on to say that the majority of people admitted to state hospitals for the first time have never seen a psychiatrist until they arrive at the institution. He attributes this in part to the relatively few psychiatric specialists available, stating that "of about 2,300 psychiatrists in this country, approximately 54 per cent are employed in mental institutions, where



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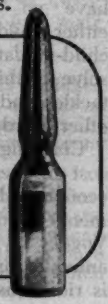

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they are for the most part unavailable for early treatment designed to prevent hospitalization."

According to Vogel, full-time child-guidance clinics are provided in only twenty-seven large cities and are almost nonexistent elsewhere. Furthermore, he states, nearly two-thirds of cities with populations of 50,000 to 100,000 have no psychiatric clinics for either children or adults. A good child-guidance clinic, he says, can solve a third of the problems it tackles and definitely improve another third.

Claiming that the total national cost of mental disease (including economic loss due to unemployment) is now $777,000,000 a year, Vogel says the $2,000,000 spent annually on research in this field is ridiculously small. He advocates a nation-wide program of mental hygiene, in which existing public health services would play a basic role. It is not, he says, the responsibility of the National Committee for Mental Hygiene (founded in 1909 and supported by private subscriptions) to establish such a program, though he credits the committee for improving state hospitals, developing mental-hygiene techniques, educating the public, and establishing demonstration clinics.

In similar vein, Watson B. Miller, Assistant Federal Security Administrator, reporting mental hospitals to be badly overcrowded, urges the adoption of a more comprehensive program for mental health, saying that "psychiatric knowledge already far outstrips its application."

Emphasizing the fact that general practitioners have not been trained to recognize mental disease in its early stages, Mr. Miller contends that such training should become a "must" in both undergraduate and graduate medical education. "Not only the major share of case-finding but even a part of treatment can be done by the well-trained general practitioner," says this layman.

He further recommends (1) more intelligent commitment through revision of outmoded and inhumane state laws; (2) elimination of politics in the operation of state hospitals; (3) better opportunities therein for physicians and nurses; (4) education of the public to the advantages of psychiatry, which "has done a meager and ineffective job of making itself known."

Concerning the help which general practitioners can give in reducing the incidence of mental disease, Mr. Miller echoes the belief of many in the profession. For outside of

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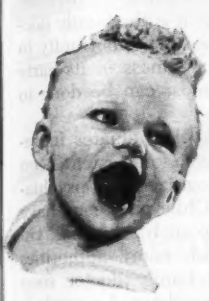
In many instances, the infant diet is low in iron and thiamine. This deficiency can be offset easily and inexpensively by the use of Gerber's Strained Oatmeal supplementing the usual milk or formula. This enriched cereal was developed by qualified infant nutritionists to meet the five main requirements of a good baby cereal.



1. *Nutritional Value.* This cereal is enriched with vitamins of the B complex as well as iron. An ounce will supply a generous intake of iron as well as a sufficient amount of thiamine for normal infants.
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4. *Appetizing Taste.* The taste of Gerber's Strained Oatmeal is unusually pleasing. Infants appreciate that good flavor as they grow older!
5. *Easy to Serve.* Gerber's Strained Oatmeal is pre-cooked. Add hot or cold milk or formula to secure the consistency desired.

Iron and Thiamine Values of Gerber's Strained Oatmeal	Thiamine mg.	Iron mg.
Minimum daily requirement for infants ..	0.25	7.5
Recommended allowance	0.40	6.0
One ounce Gerber's Strained Oatmeal ..	0.42	11.7
Calories per ounce: Gerber's Strained Oatmeal....		109

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the advent of more psychiatrists into private practice, the G.P. appears to offer the only means whereby the gigantic job of lessening the hospitalization rate can be implemented.

That vast possibilities lie in the idea was suggested as far back as 1935 by the late Dr. William Alanson White, superintendent of St. Elizabeth's Hospital, Washington, D.C. In discussing ways to relieve the economic burden of caring for the mentally affected, Dr. White said:

"It is, to my mind, quite possible, at least in selected and appropriate communities, to undertake the care of mentally ill patients in their own homes, and to remove to hospitals only people who are seriously sick or dangerous to themselves or others. In fact, this plan is already in operation to some extent in Australia, and its advantages are obvious in saving an enormous expenditure upon huge institutions. A plan of this sort, however, cannot become effective in any large way until the average social worker, the average nurse, and the average physician are much more highly trained in the symptoms and care of the mentally ill than they are at present."

During the last six or eight years, certain state institutions have been experimenting with family care; yet latest estimates show that only about 1,500 patients in the entire country are now being so treated, and these are still under the close supervision of the institutions' psychiatrists. As far as can be learned, few, if any, have been released to the care of family physicians.

To what extent G.P.'s can tackle mental hygiene without specialized training is a moot point. Yet psychiatrists agree that it is the family doctor who has the best opportunity to discover mental illness in its early stages, when most can be done to remedy it.

Medical school graduates in recent years have, to some extent, been trained to recognize neuropsychiatric disorders. Older physicians have had little or no such schooling. On the other hand, many authorities hold that the family doctor soon comes to be something of a psychologist—often a better one than he realizes.

Typical of some comments are these made editorially by the Journal of the Missouri State Medical Association:

"The practicing physician should know more about the mind than anyone else. But he does not. He states that psychiatry and psychology are a closed book. He is negativistic and defeatist . . .

"Unless he realizes that these conditions [colitis, constipation, headache, backache, insomnia, anorexia, etc.] have a definite psychiatric background, and unless the environment of the patient and his reactions are studied, these conditions cannot be

corrected. The layman is beginning to realize this. If the doctor gives a pill or a potion and tells his patient to come back next Tuesday, he need not be surprised if he never sees the patient or his family again . . .

"Let us stop saying, I know nothing of these things. It is not a true statement. Every successful practitioner is a good psychologist, otherwise he would not be successful . . .

"The physician must not be afraid of psychiatry. The procedures of psychotherapy are constantly being publicized. Articles in [medical] journals offer the general practitioner a liberal education . . .

"Physicians themselves are responsible for the growth of the cults, because they have shut their eyes and ears to modern psychiatry."

Statistically, the principal mental ailment with which psychiatrists are now concerned is dementia praecox, which is responsible for about 20 per cent of all first admissions to state hospitals.

That it is preventable to a considerable degree is the belief of Dr. Edward A. Strecker of the University of Pennsylvania medical school. It is his opinion that a wider understanding of the mental hygiene of childhood is urgently needed; that adequate examinations of the minds and personalities of children are necessary to help them reach mental and emotional maturity.

New emphasis has lately been put upon the whole problem of mental disease by the alarming number of psychiatric rejections and discharges by the armed services. Several important considerations must be taken into account, however, in any study of the figures.

By May 1943, draft boards had rejected more than 700,000 men (7 per cent of all examined) for nervous and mental disorders, even though psychiatrists admit that the pre-induction screening is a coarse one. Yet such rejections are not a sound index to the incidence of mental disease, for the great majority of these men are perfectly able to carry on civilian responsibilities; it is only their unfitness for the rigors of service that is indicated.

More disturbing are the figures on discharges: About one-third of the service men now being released are said to be mentally or emotionally disabled.

Here, a serious rehabilitation problem confronts the government. Some 30,000 such casualties of the last war are still in veterans' hospitals; and to date about a billion dollars has been spent in caring for that conflict's mentally ill.

Rehabilitation clinics are now being organized to help emotionally disabled ex-service men who do not require hospitalization. Those who do will be admitted to the institutions conducted by the Veterans Administration, where many will no doubt become permanent patients. —CARY APPLETON

Insurance Questions & Answers

Wide rate variation; disability clause; 16 per cent interest; other issues

Q.: I pay $30 yearly for malpractice liability insurance, $5,000-$15,000 limits. Is this charge standard in all companies in my state?

A.: No. Malpractice rates, while approved by your (N.Y.) state insurance department, are not required to be uniform in all companies—even though the protection offered is practically identical. This rate variation is illustrated in the accompanying table. From any one of the companies listed there by number, the G.P. doing surgery and using X-ray for diagnosis only can buy a policy with equal safety at the different rates cited:

Cost of Malpractice Insurance
In New York State
$5,000-$15,000 Limits

Company Number	Annual Premium	Dividend	Net Cost
1	$40	nil	$40
2	30*	nil	30
3	30	nil	30
4	28	nil	28
5	28**	15%	23.80

*$35 if major surgery is done.
**Premium for New York City; elsewhere in state, $25, dividend 15%, net cost $21.25.

In your case, practicing outside New York City, the annual net cost may range from as much as $40 to as little as $21.25 (allowing for the dividend which, of course, cannot be guaranteed). The highest rate, it will be noted, is almost double the lowest; yet it affords no better protection.

(Note: This wide cost difference prevails also in a number of other states, but not in all.)

Q.: I have taken over the practice of a physician in the Army. He continues to be responsible for all overhead. I use his equipment. If there should be an accident on the premises would his public liability insurance cover me?

A.: No. In the event of a personal injury not stemming from any professional act of yours, the plaintiff would most likely sue you and the other doctor jointly. The nature of the accident and of the arrangement with your colleague in the Army would then determine where liability rested. Your risk can best be covered by having your name added as a co-insured. Additional cost: about 25 per cent of the present premium.

Q.: The agent for the company whose life insurance I'm considering says he cannot include provision in the policy for a monthly income for life in the event of prolonged sickness or disability. He knows of no companies now offering such coverage. Are there any?

A.: Yes, several. But none offers it at the relatively low price for which it was sold several years ago. It is currently available in the forms and at the yearly premiums listed below

(premiums quoted are in addition to the cost of the life insurance which must be bought to get the disability protection; rates used for illustration presuppose the purchase of ordinary life at age 36 without the charge for premium waiver which must be carried with the disability coverage):

(a) $10 monthly income for life per $1,000 of life insurance. Clause terminates at age 60. First four months not covered. Yearly cost: $7.16. Maximum issued to physician: $125 monthly.

(b) $7.50 monthly for life per $1,000 of insurance. Clause terminates at age 55. First five months not covered. Yearly cost: $3.32. Maximum issued varies.

(c) $5 monthly for life per $1,000 of insurance. Clause terminates at age 55. First five months not covered. Yearly cost: $2.53. Maximum issued varies.

The objection to types (b) and (c) is that disability must start before age 55 and that $10,000-$20,000 of life insurance must be bought in order to get a monthly income of as little as $75-$100.

A modified form of disability protection now available requires no concurrent life insurance. It pays $100 monthly for ten years if house-confined or $50 monthly for 20 years if not confined. Company's aggregate maximum liability: $12,000. Contract terminates at age 60. First three months not covered. Yearly cost: $64. Maximum issued: $100 monthly.

Q.: My brother, a physician, has an incurable disase. He will probably live five years at most. He carries a sizable amount of life insurance (now desperately needed) but lacks the resources to keep it in force. Is

there a solution to his problem? He does not have premium waiver.

A.: If the policies have cash value, they include an extended term insurance clause. This clause permits discontinuance of premium payments and use of the cash value to keep the coverage in force for a period specified in the policies. Ordinary life, for example, issued at 33 and held for only three years can by this means be kept in force for an additional two years and two months. The greater the cash value, of course, the longer the extended term insurance option will keep a policy in effect, except at more advanced ages.

Q.: Because my wife has accumulated a good deal of sterling silver, several valuable art objects, and some valuable jewelry, we carry $5,000 of residence burglary and theft insurance. The balance of our effects we're not concerned about. For this $5,000 coverage, we pay about $37 yearly. Can this cost be reduced?

A.: Yes, by the purchase of so-called *specific* insurance, meaning burglary and theft insurance on the silver, art objects, and jewelry in your home—but on nothing else. To enjoy the lower cost of specific insurance, you must list and place a value on each item to be insured (the sterling silver can be bulked). The cost for $5,000 of specific insurance in your state (Conn.) would be about $12.25 a year provided you have your office outside your home (rate somewhat higher in a home-office). A further saving can be made by having the policy issued for three years instead of one.

Q.: What interest am I charged for the privilege of paying my life insurance premiums every three months? My quarterly outlay is $58.30 for a $10,000 policy bought when I was 35.

A.: On the surface you appear to be paying only 6 per cent. Yet actually, it is 16 per cent.

Your present quarterly payments of $58.30 total $233.20 yearly. On an annual basis you would pay $220. The difference ($13.20) is 6 per cent of $220.

But there's more to it than that. For when you bought the policy you had to pay immediately the first quarterly premium. At no time did the company lend you any part of $220 for a full year, though it charged you a full year's interest on the full amount. The company really lent you three-fourths of the year's premium for three months, half of it for six months, and a quarter of it for nine months. Result: a 16 per cent interest charge that could have been avoided had you originally bought four $2,500 policies written on an annual premium basis to take effect simultaneously, with premiums spread three months apart.

At 35 your life expectancy was 32 years. The $13.20 annual interest you pay, multiplied by 32 and not compounded, equals $422.40 tossed away needlessly on a $10,000 policy. There's no relief for you now but to pay annually. —J. EDWARD DEMING

MALPRACTICE Prophylaxis

Lessons learned from actual cases observed in court

Case: A fracture of the tibia. The patient was dissatisfied with the attention he had received and with the result. He complained of pressure sores which developed under the cast. He also complained that he could not get the doctor when he needed him and that the doctor constantly criticized him for being "unreasonable." Finally the patient discharged the physician and endeavored to satisfy him by payment of $150 (probably a reasonable amount in the circumstances). The doctor demanded more. Without waiting for the time provided by the statute of limitations to pass (in California, one year for a tort action), the physician brought suit to collect his fee. A retaliatory cross-complaint for malpractice resulted.

Comment: The patient should be seen often enough and be given sufficient attention that he may feel he is being thoroughly and properly looked after. If he becomes dissatisfied or is not doing well, consultation is desirable both for his protection and for that of the physician. Take advantage of any protection afforded by the statute of limitations.

Case: A young woman had a chronic lesion of the skin of one of her hands. An X-ray treatment was given which caused a severe burn. Some permanent disability resulted. There was contradiction as to the length of the treatment, the distance of the target, and other factors in connection with treatment. It appeared that the physician who administered it had little or no experience with X-ray therapy. His machine had not been checked in any way since it had left the dealer. The defendant had purchased it from another physician. This case was finally settled by payment to the patient.

Case: A caesarean section. Routine preparation of the operative field, in the operating room; ether wash, dried; painting with iodine, excess removed with alcohol.

The patient presented what was apparently a local chemical burn, exact cause unknown. She was apparently hypersensitive to one of the chemicals used in the combination. A physician who visited the patient socially suggested that she had grounds for a suit. The jury's verdict was given for the defendants

▶This article, which approximates a portion of the author's book, "Medical Malpractice" (C.V. Mosby Co.), explains, by precept and example, how to avoid situations that may lead to lawsuits.

—physician, hospital, and operating room nurse.

Comment: From an analysis of the testimony, it appears that despite the ubiquitous physician-investigator, there would have been no suit had the attending surgeon exercised more tact in his handling of the patient. From the moment of reaction from the anesthetic, the patient was resentful, complaining and uncooperative. The surgeon further antagonized her by his remarks and attitude. The good-will of the patient might have been retained by a frank and sympathetic explanation, preferably with the aid of a consultant.

Case: A Colles fracture, with only fair functional result. The attending physician had been unduly optimistic in his prognosis. The patient had been led to believe that the matter was trifling, that everything would be perfect. When a perfect result was not obtained the patient sought medical care elsewhere. The first physician's professional attention (aside from his unwise optimism) seemed to have been excellent; nevertheless the second physician permitted himself to be highly critical of his predecessor's work. Result: suit, with a verdict—but some unfavorable publicity too—for the first physician.

Comment: This case demonstrates the touch of another physician-investigator. Without troubling to ascertain the facts, he precipitated an unfounded malpractice action by his destructive and unethical criticism. It is never fair or proper to criticize the treatment employed by another physician without being in possession of the full details. According to law, a bad result in itself raises no inference of malpractice. The ques-

tion is always: Did the physician possess and exercise that usual or ordinary degree of skill and care commonly possessed and exercised by physicians practicing in the same community in the diagnosis and treatment of similar cases?

To illustrate how stories differ:

A patient said that she had had her appendix removed; that it had been an interval operation; that prior to the operation she had been in splendid condition; that she had been neglected and maltreated during the post-operative period and finally discharged by the surgeon in her present deplorable condition. She added that because of the heavy hospital and medical expense she had been unable to have needed secondary surgery done. Examination disclosed a large, irregular, and ugly abdominal scar, with massive ventral hernia.

The operating surgeon's story, supported in detail by the hospital record, was as follows: Patient obese, general condition poor, critically ill, verging on delirum tremens; appendix ruptured, multiple abscesses in right lower abdomen, several drains used; patient suffered an acute, post-operative, alcoholic delirum for seven or eight days; a moderate fee was charged; arrangements were made to have secondary surgery at the general hospital but the patient refused.

Case: A six-month-old baby with diagnosis of otitis media, bronchitis, and diarrhea. The baby was given one treatment by diathermy, one pad over front and the other at back of chest. The pads were covered with towels, 1,500 milliamps were used, and an interval timer was set for ten minutes.

The physician went to his desk in the next room, a communicating door being left open, to write some prescriptions. The mother was instructed to hold the baby; to observe whether the pads remained in place and whether the child voided; and to call the doctor at once if necessary.

How long the doctor remained out of the room, and whether the mother called him, was in dispute. The mother, a Mexican woman, had only a limited command of English.

When the physician returned, he observed that the posterior pad had slipped down to the buttocks and that the baby had had a bowel movement and had voided. On examination, it was discovered that the baby had sustained a third-degree burn, about 3 by 5 inches on the right buttock.

After the trial had been in progress for about four days, the case was settled by payment of a sum of money to the plaintiff.

Comment: Malpractice claims resulting from diathermy burns are very difficult to defend. In ten years in Los Angeles County, there has been recovery by the patient in 95 per cent of claims of this type. It is certain that from the point of view of malpractice risk, the use of dia-

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The topical applicatio of the vitamins A and D in combination and in the same ratio as found in cod liver oil results in:

"(1) a remark ble regeneration of all sorts of tissue defects

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"(3) epithelize more satisfactorily and heal more rapidly than with other methods."*

White's Vitamin A and D Ointment now is extensively used in major and minor burns, even of the face, slow-healing post-operative lesions, crushing and avulsive soft-tissue injuries, indolent ulcers and certain dermatologic affections common to industry.

Pleasantly scented; no objectionable oiliness; will not become rancid. In 1.5 oz. tubes; 8 oz. and 16 oz. jars; 5 lb. containers.

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*Hardin, P. C.: South. Surg., 10:301 (May) 1941.

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White's PRESCRIPTION vitamins

thermy is hazardous. Especially is this true of diathermy in the hands of a physician who is not trained in its use or who uses it only incidentally. It is striking that almost no claims of injury of this sort have been made against specialists in physical therapy.

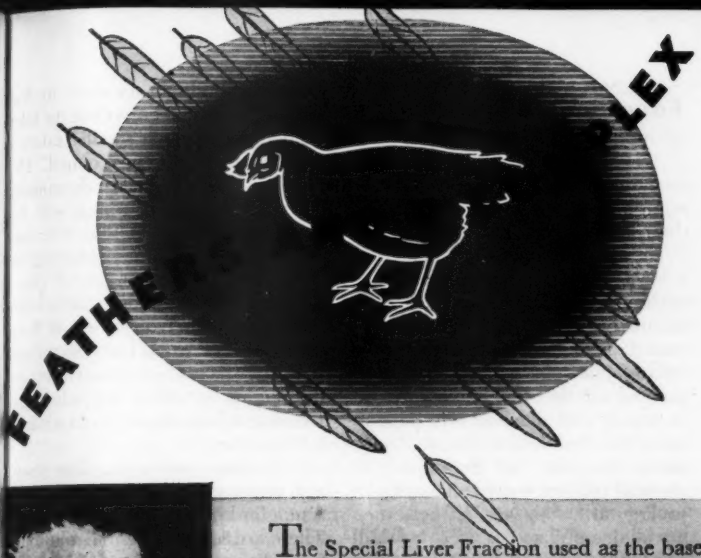
Case: No X-ray was taken after the reduction of a fracture. A bad result followed. Later an open reduction was done. The physician claimed that the patient had failed to keep appointments (including two to have X-rays taken after the reduction), had failed to follow instructions, and had discontinued treatment prematurely and without notice. All this was denied by the patient. The jury was unable to reach a verdict. A retrial seemed probable.

Comment: Take X-rays and more X-rays in every injury, real or suspected, of a bone or joint. When a patient fails to follow instructions or discontinues treatment prematurely, write a letter comprehending the circumstances and your recommendations, and send it to the patient at once. File a carbon copy.

Case: Normal gestation, normal delivery, and normal puerperium in hospital. Home on tenth day. Immediately began to flow. Gushing hemorrhage on twelfth day. Patient returned to hospital. Blood studies were made: red blood cell count, hemoglobin estimation, typing, etc. The patient was transferred and curetted with dull curet. No placental tissue found. Packed.

At this point the first physician was discharged. The succeeding physician moved the patient to another hospital. According to the second hospital's chart, a piece of placenta about 7 cm. across was found on the packing when it was removed. Nevertheless, the second physician curetted the patient. The patient ran a high spiking temperature and was very ill for a number of days. She was treated with sulfa drugs and repeated transfusions. The first physician was sued on the theory that he had failed to remove all the placenta. The second physician appeared as a medical expert witness for the plaintiff. The jury brought in a verdict in favor of the defendant.

Comment: The succeeding physician took over this patient without contacting the first physician and, apparently motivated by the need to justify himself, declared that he took charge because action was necessary to save the patient's life. The bill he eventually rendered was, considering all the circumstances, excessively large. It was fortunate for the second physician that the statute of limitations as applied to him ran out before the action against the first doctor came to trial. In the opinion of physicians who studied the case, if the patient had a justifiable complaint against anyone, it was against the succeeding physician. —LOUIS J. REGAN, M.D., LL.B.



K No. 531 fed diet sup-
adequate in protein,
drate, fat, minerals,
established vitamins.

K No. 633 fed same diet,
mented with 1% of the
oncemin Liver Fraction.

The Special Liver Fraction used as the base of Beta-Concemin provides the *complete* B complex.

This has been shown in experiments where chicks fed a diet supplemented with the Beta-Concemin Liver Fraction develop optimum feather growth, whereas those fed a diet supposedly adequate in all *known* vitamins do not feather normally, as indicated in the photographs.

Moreover, this Liver Fraction has a favorable effect on growth, mortality and hemoglobin formation in the laboratory animal.

BETA-CONCEMIN

Brand of B Vitamins

POTENT VITAMIN B COMPLEX

Elixir Beta-Concemin is available at all prescription pharmacies in 4-oz. and 12-oz. bottles; **Tablets Beta-Concemin** in bottles of 100; and **Capsules Beta-Concemin with Ferrous Sulfate** in bottles of 100.

Trademark "Beta-Concemin"
Reg. U. S. Pat. Off.

MERRELL

110th Year

Education: Postwar

[*Continued from page* 35]

recommend those hospitals best equipped to take on extra teaching duties.

Although this basic technique is a a bit general, the council feels that nothing more definite can be planned until the armed services reveal their demobilization plans. Dr. Victor Johnson, council secretary, pointed out that the whole question of supply and demand will depend upon the demobilization rate. "Suppose," he said, "we find that 300 medical officers want residencies in urology after the war. If these men are all demobilized at once, we shall need 300 residencies. But if they are released over a three-year period, 100 will be enough."

Another factor will be the method of demobilization. Suppose the services decide to release all obstetricians and gynecologists as soon as the war ends, and to demobilize surgeons more slowly. There will then be a heavy demand for residencies in obstetrics and gynecology while posts for surgeons may go unfilled.

The fear of some observers that young medical officers, accustomed to relatively high incomes in th services, will not be willing to tak residencies at much smaller salarie is discounted by the council. D Johnson believes that inducemen for post-graduate training will b greater after the war than ever be fore because of new openings i tropical medicine, industrial pra tice, etc. He conceded last mon that some men won't want to tak post-graduate work, but pointed ou that there have always been interne thoroughly qualified for advance training, who preferred to go straigh into practice.

Refresher courses for older me also under study by the council, pre sent a far knottier financial problem There are several possible solutions Subsidies may be provided by foun dations. The AMA may set up a spe cial fund for this purpose. It may b possible to extend the Wartim Graduate Medical Meetings finance by the AMA, the American Colleg of Surgeons, and the American Co lege of Physicians, and offered i cooperation with the Army, Navy and Public Health Service.

The AMA strongly advocates tha older medical officers be demobilized first so there will be an adequate supply of teachers to instruct the younger ones. —P. A. MARVIN JR.

The Newsvane

Mental Care Subsidy

The problem of mental illness in the U.S. has grown so grave that only a Government subsidy of $1,000,000,000 can solve it, according to Dr. Israel Strauss, president of Hillside Hospital, Queens, N.Y. He said last month that nonprofit, nonsectarian institutions needed Federal support because communities could no longer cope with the growing financial burden.

Credit Data

Although the facilities of the nation's credit bureaus are available to physicians, and many use them regularly, the Associated Credit Bureaus of America is not satisfied that individual agencies have been able to give doctors exactly the kind of service they need, according to A. B. Buckeridge, president of the organization. For that reason, the CBA has inaugurated a national survey to determine the ideal formula of service for a professional division that it has been planning for a number of years. Physicians will be asked just what kind of information they require and how it should be furnished. Bureau managers who have been successful in developing professional service will contribute data based on their experience.

Mr. Buckeridge points out that retailers now extend credit in the billions annually, at a loss of only a fraction of 1 per cent, by employing modern credit and collection methods. His organization plans to make helpful credit data available to all practitioners and to aid them and their office assistants in collections.

Boy Was Girl

Osteopath John M. Andrews testified that he had held up the newborn infant and, viewing it from the rear, noted that it had two hands and two feet. "It's a boy," he told the nurse and turned to attend the mother.

Thus the genesis of the Hardwig "switched baby" suit in Los Angeles. For when Mrs. Hardwig returned home with the baby she found it was a girl. Charging that her infant had been exchanged with that of some other mother, she and her husband brought suit for $500,000 against the South Hoover Hospital, later settled it out of court.

Mannix Proposal

Establishment of an "American Blue Cross" to furnish prepaid hospital and medical care on a nationwide basis is impracticable, Dr. Harvey Agnew, editor of the Canadian Hospital, said recently in the journal Hospitals. While sympathetic with the aim of John R. Mannix, who proposed the new organization, Dr. Agnew cited a number of factors that would militate against it.

The American Blue Cross, according to Mr. Mannix, director of the Chicago Plan for Hospital Care, would charter local medical plans

throughout the country to provide comprehensive care on a prepayment basis, as described at length in MEDICAL ECONOMICS last month. It would be controlled by the AMA and AHA.

Commenting on a suggestion that premium rates should be set high enough to cover the indigent, Dr. Agnew said that "in time of depression—if not before—I fear the burden would be so great it would soon be turned over to the Government. One would be more optimistic of a combination voluntary hospital-medical plan with the premiums for the indigent contributed from Government sources."

Dr. Agnew was dubious about the plan's practicability for other reasons. For one thing, he said, "Voluntary plans cannot effect complete coverage; the ones most needing coverage—the low-paid—and those best able to contribute large supporting premiums—the wealthy—would be the last to come in."

He also felt that the costs of providing full health benefits "without restrictions or limitations" as proposed, with various benefits left "entirely to the discretion of the attending physician," would be so high that voluntary membership would soon lag.

"The grading of premiums to income is fair, but when it reaches 3.6 per cent or higher, as it well might for full benefits, the average person of good income will demur. Work out your own contribution on that basis."

Dr. Agnew declared that the "modern conception of health emphasizes prevention as well as cure. No plan can be fully satisfactory until it provides adequate preventive as well as therapeutic services."

Stating that it "is highly desirable to retain the principle of personal responsibility and to minimize bureaucratic regimentation as under state medicine," Dr. Agnew concluded that the logical solution of the problem would be a health insurance partnership with the state, embracing obligatory participation on a contributory basis, with state assistance for special undertakings.

'Package' Plans

Although recognizing "the importance of cooperating with commercial carriers in many instances," the Blue Cross Hospital Service Plan Commission has taken official action "favoring the furnishing of hospital and medical service on a non-profit basis." In connection with a survey by its committee on package plans,

IF THE TASTE IS PLEASANT

The palatable feature of Phillips' Milk of Magnesia is important—especially when administered to children.

Since there is no taste objection, this gentle laxative is readily acceptable.

Owing to the low solubility of magnesium hydroxide, the action of Phillips' extends into the intestines without irritation. No griping or leakage.

Not only is it "standard for children" but for over three decades it has been prescribed by physicians for its mild laxation and gastric antacid properties in such conditions as colds, peptic ulcer and hyperacidity.

Supplied in both liquid and tablet forms.

DOSAGE:—

As an antacid—1 to 4 teaspoonfuls (1 to 4 tablets).
As a mild laxative—2 to 4 tablespoonfuls.

PHILLIPS'
Milk of Magnesia

Prepared only by

THE CHAS. H. PHILLIPS CO. DIVISION
of Sterling Drug Inc.
170 VARICK STREET, NEW YORK 13, N. Y.

the commission stated it did not believe it was "in the public interest for a Blue Cross plan to serve as agent for a commercial organization for the indemnification of hospital or medical expenses."

The survey did reveal, however, that twelve Blue Cross plans had joint administrative arrangements with medical-society-sponsored programs providing physicians' service, and that negotiations were progressing for additional arrangements of the same sort.

Operators of ten of these package plans indicated a willingness to cooperate with employers and commercial insurance companies; so did more than half of some forty-five non-package plan administrators.

More Army Nurses

The authorized number of nurses for the U.S. Army has been raised from 40,000 to 50,000. Last month actual enrollment was 38,000.

Eye Bank

Nineteen nearby hospitals will draw on the eye bank established at New York Hospital for preserving healthy human corneas for transplantation to patients whose corneas are opaque. These institutions will, in turn, deposit with the bank corneas collected from blind donors and from deceased persons who have bequeathed their eyes to the bank. Eyes must be removed within four hours, but delays may be encountered in bequests because New York State law requires next-of-kin permission even though the deceased has willed his eyes for such use. New techniques, which permit storing eyes or corneas for six days before implantation, have made the bank extension plan possible.

Rheumatic Fever

"Rheumatic Fever in Children," a 29-page handbook for physicians, has been published by the Metropolitan Life Insurance Co. It was prepared in consultation with the American Heart Association, the American Academy of Pediatrics, the Children's Bureau of the U.S. Department of Labor, and the U.S. Public Health Service.

For the public, Metropolitan has prepared a pamphlet, "What About Rheumatic Fever?" and a window card in color, "Rheumatic Fever—Dangerous Disease of School Years."

Debate LaGuardia Plan

While organized medicine still protested Mayor Fiorello H. LaGuardia's failure to consult with his

[*Continued on page* 114]

Successful management of high blood pressure calls for a regimen which is adjusted to individual requirements. Physical activity is generally curtailed and overwork is avoided. In certain circumstances special diets are prescribed and the use of stimulants is restricted.

These measures are often supplemented with the administration of Theominal. This combined vasodilator and sedative aids in reducing blood pressure to a more normal level. As a consequence hypertensive symptoms are relieved and the risk of complications is reduced.

DOSAGE: The customary dose of Theominal is 1 tablet two or three times daily; when improvement sets in the dose may be reduced. Each tablet contains theobromine 5 grains and Luminal* ½ grain.

*Luminal (trademark), Winthrop Chemical Company, Inc., brand of phenobarbital.

Theominal
Reg. U. S. Pat. Off. & Canada

Supplied in bottles of 25, 100 and 500 tablets.

Winthrop
CHEMICAL
COMPANY
INC.
Pharmaceuticals of merit for the physician
NEW YORK, N. Y.
WINDSOR, ONT.

medical advisory committee before announcing his comprehensive prepayment plan for New York City, the Mayor last month went ahead with the project.

He announced that the New York Foundation had agreed to underwrite $150,000 of the $250,000 needed to start the program, and said incorporation papers were to be filed for its operating organization.

Head of the New York Foundation is David M. Heyman, who was vice chairman of the special committee that prepared for the Mayor the data on which he based his plan of complete medical and hospital care for all persons living or working in New York City, with incomes up to $5,000 a year.

Mayor LaGuardia reported "universal encouragement" from the public. But Dr. W. Guernsey Frey, president of the Queens County Medical Society, reiterated that the plan had not been "presented to the medical advisory subcommittee, on which were included representatives of the New York, Kings, and Queens County Medical Societies.

"We are certain," Dr. Frey continued, "that no plan of medical insurance can provide a proper quality of medical care when it denies the patient free choice among the reputable physicians of his community."

Dr. Frey wrote the Mayor that the Queens society wanted to cooperate with him, appreciating that "your intentions are the best," but added:

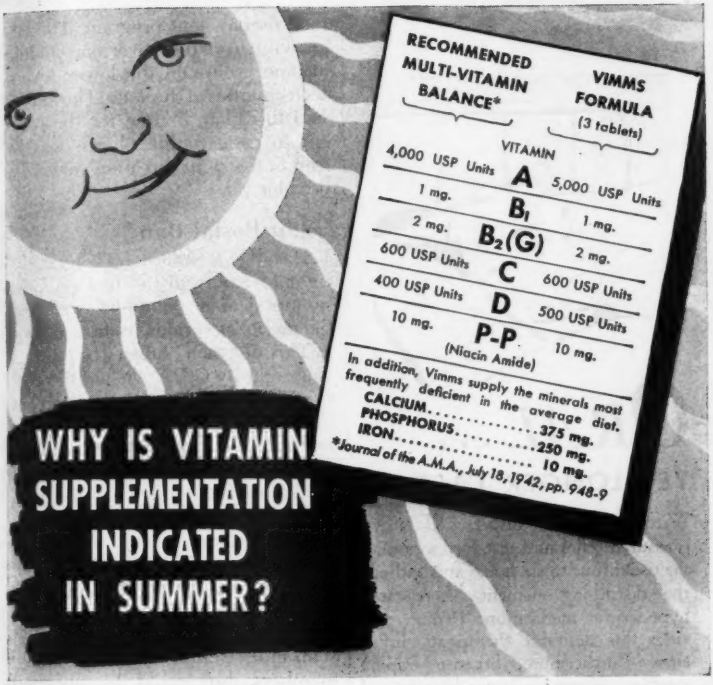
"The institution of a closed-panel system, limiting participation in the plan to a chosen few, would seriously undermine the present high quality of medical care and would deter qualified physicians from practicing their profession in this city."

On behalf of the Queens society, Dr. Frey asked Mr. LaGuardia to "meet with the official representatives of the five county medical societies before any decisive steps are taken in the organization of your plan."

Later the Mayor told reporters that Dr. Frey was "coming to see me soon. He's entitled to a hearing."

Critics meanwhile raised another objections: beneficiaries, they said, would swamp New York's hospital facilities, necessitating new construction at a cost which neither plan subscribers nor taxpayers could bear.

The Mayor, for his part, heaped congratulations on the Medical Society of the State of New York for its approval of the recently announced United Medical Services,



HAVE YOU EVER THOUGHT that "summer slump" may often be traced to the poorer nutritive quality of summer meals? This is partly due to the instability of labile factors in food, and to the mistaken belief of many that less meat should be consumed during hot weather. American diets reach their lowest mark in summer![1]

The Vimms formula (3 tablets) provides high nutritional insurance for your patients. Vimms contain full minimum requirements for *all* the vitamins known to be essential in the diet, and ample quantities of Calcium, Phosphorus, and Iron. No product offering only one tablet or capsule a day can provide all these minerals and vitamins. That's why Vimms come in *three* easily swallowed tablets a day.

Vimms' potencies are chemically and biologically controlled. Tests on human subjects show that the vitamins are readily available for absorption. The tablets are palatable; can be chewed or swallowed.

For professional samples, write to Pharmaceutical Division, Lever Brothers Company, Department ME-23, Cambridge, Mass. (Offer good in U.S.A. only)

50¢ for 24; $1.75 for 96; $4.50 for 288

[1] *Stiebeling-Phipard, U. S. Department of Agriculture*

Inc., prepayment program. The latter will cover the lower and middle income groups in the lower seventeen counties of the state. The Mayor said this plan, limited for the present to catastrophic illness, was "a step in the right direction" toward a broader plan.

Fight Postal Ban

Has the Postmaster General the right to bar from the mails a Consumers Union pamphlet weighing the merits of various contraceptives?

This question, subject of a three-year fight by C.U., reached the U.S. Court of Appeals in Washington last month. The court delayed its decision until the Government could enter a reply to C.U.'s brief.

The brief contended that the pamphlet was not within the scope of the law under which Postmaster General Frank G. Walker held it unmailable. In support of this contention, the Consumers Union counsel explained that the pamphlet was not sent indiscriminately to its 60,000 members, but could be obtained only by those who submitted a written statement that they were married and that a physician had advised their using contraceptives. In addition, he said, the pamphlet was available to social workers and physicians.

The pamphlet, counsel said, contained a "plain and sober" statement, valuable to those for whom it was intended because, he told the court some contraceptive devices are dangerous to health and others are ineffective. Besides, he pointed out, the Journal of the American Medical Association had printed articles which paralleled closely the subject matter of the pamphlet, and the Journal had not been banned from the mails. He added that the Reader's Digest had

BABY IS ONE YEAR OLD TODAY!

He has begun to take a wider variety of foods, but fundamental, as his "staff of life", is his daily milk quota.

Because of low curd tension, ease of digestion and palatability, he will delight in taking his milk ration in the form of Horlick's.

Horlick's prepared with milk is rich in muscle-and tissue-building proteins, as well as bone- and tooth-building calcium. Horlick's Fortified is reinforced with additional amounts of vitamins A, B_1, D and C.

Obtainable at all Druggists

Recommend

HORLICK'S

The *Complete* Malted Milk . . . Not Just a Malt Flavoring for Milk

HORLICK'S

printed articles on birth control, too

In reply, Government counsel argued that the distribution safeguards set up by the Consumers Union could not prevent the pamphlet falling into the hands of unmarried persons and others who had no physician's advice, and that it could be an incentive to the use of contraceptives. Asked by the court whether these arguments could also be applied to the articles in the JAMA, Government counsel replied that while the Journal was available to laymen, it usually was read by medical men. He admitted, however, that this was not so in the case of the Reader's Digest.

Raps Federal Medicine

Enactment of Wagner-Murray-Dingell-type legislation would be a gross invasion of states' rights, Governor Herbert R. O'Conor of Maryland told the 1944 Governors' conference at Hershey, Pa. Although he did not name the bill, he denounced as "dangerous" the proposed measures "whereby the Government would regulate medical science.

"While revisions and readjustments may be necessary," the Governor declared, "the medical profession can be depended upon to meet the emergency without submitting to the dictation of government."

White Paper Criticized

Under strong fire by the council of the British Medical Association are three elements of the British Government's White Paper advocating a national health service plan. The council has declared that it

1. Wants more medical men on the board which will be ultimately responsible for the service.

[*Continued on page 123*]

STAINLESS STEEL . . .

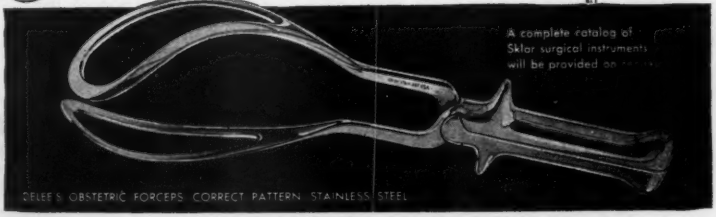
one of the century's most significant industrial innovations. Solved the corrosion problem .. brought a new kind of steel combining high tensile strength with exceptionally high ductility . . . provided greater resistance to heat . . . lighter weight . . . and a clean, thoroughly polished surface such as industry was looking for!

Perfection IN ITS FIELD

TODAY, certain grades of stainless steel are considered by many metallurgists as ideal for certain manufacturing purposes. Through new combinations of alloys . . . more intensive study of steel structure . . . research is constantly increasing the industrial usefulness of this marvelous product. Pioneers in the adoption of many industrial innovations, the J. Sklar Manufacturing Company was among the first to use stainless steel in the making of surgical instruments. Quality materials . . . quality workmanship . . . half a century of "know how" . . . that's why the name SKLAR is synonymous with surgical instruments that are tough, resilient, durable, dependable . . . why SKLAR is first choice of the profession.

Sold only through accredited surgical instrument dealers.

Sklar LONG ISLAND CITY, N. Y.



2. Favors service only for "those who need it" (the need to be determined by an income test) rather than "for all who want it."

3. Objects to the establishment of health centers without a prior period of careful trial and experiment.

Slain in Gun Battle

Dr. W. G. Allison, 75, Hope, Ark., was shot to death and William Schaffer, Little Rock narcotic agent was wounded in the shoulder in a recent gun battle in the physician's office. Joseph Bell, in charge of the Kansas City district narcotic bureau, escaped injury, though a bullet passed through his coat sleeve.

The physician had been arrested by Schaffer three weeks before, charged with illegal sales of narcotics and held to await action of the Federal grand jury. Prior to the shooting, the two agents had gone to his office to question him further. The doctor opened the door of his safe, presumably to obtain records.

"I saw he had a gun and grabbed him," Bell said later. "He pointed it at my chest and fired. The bullet went through my sleeve. Schaffer pulled his gun and hit the doctor over the head, but failed to subdue him. The doctor shot Schaffer in the arm. Schaffer then opened fire."

Dr. Allison was shot four times and died almost instantly.

The shooting climaxed a series of narcotic investigations in which charges of illegal sales were filed also against another physician of the city. A sentence of eighteen months imprisonment was given a physician in a near-by town on similar charges.

Federal Health Agency

Over-all authority to institute programs for the protection of the people's health and security would be entrusted to a new Federal agency proposed by Senator Claude D. Pepper (D., Fla.), who announced at the recent National Wartime Conference in New York that he would sponsor a bill to set up the agency. He said the new unit would coordinate all data concerning the health and welfare of the nation, and would be empowered to issue pertinent directives to other Federal bureaus.

Presiding over a panel discussion on "standards of living," Senator Pepper said that about 20,000,000 persons in the white-collar and fixed-income groups, because of rising wartime prices, have been forced to forgo medical attention.

"The purpose of wage controls," he declared, "was never to hold substandard wages at a level that deprives the worker of such basic necessities as medical and dental care. Nevertheless, this is the effect that our present policies are having. Adjustments which will correct unequal sacrifices are urgently needed."

Dental Department

The Navy should set up a separate Dental Department equal in ev-

Amodrine

The ingredients of the Amodrine formula account for its success in the treatment of bronchial asthma and hay fever symptoms:

Aminophyllin-Searle 1½ gr.

The effectiveness of Aminophyllin in asthma and its definite antispasmodic effect, together with its myocardial stimulant and diuretic actions, are well established.

Racephedrine Hydrochloride ⅜ gr.

Acting as a stimulant to the sympathetic nervous system, the principal effects observed are relaxation of the smooth muscle fibers of the bronchi and bronchioles, with corresponding bronchial dilation.

Phenobarbital ⅛ gr.

This valuable hypnotic-sedative has, among other effects, a sedative action on respiration, lessening the frequency of breathing. By allaying apprehension and nervousness—important contributing factors—it assists in preventing attacks.

A summary of the actions of Amodrine is:

Bronchial and bronchiolar dilator
Antispasmodic and smooth muscle relaxant
Myocardial stimulant and diuretic
Nervous system and respiratory sedative

Supplied in bottles of 100 and 1000 tablets, plain or enteric coated (the latter for delayed effect).

G·D·SEARLE & CO.
ETHICAL PHARMACEUTICALS SINCE 1888
CHICAGO
New York Kansas City San Francisco

Amodrine is the registered trademark of G. D. Searle & Co.

SEARLE
RESEARCH IN THE SERVICE OF MEDICINE

ery respect to the Medical Department, asserted the Minnesota State Medical Society in a recent resolution. The Buffalo (N.Y.) Inquirer-Express, commenting on a bill endorsed by the American Dental Association to establish a post of Naval director of dentistry, said that "At present the Dental Corps has somewhat of an anomalous character, being defined, according to Navy regulations, as distinct from the Medical Corps, yet apparently being dominated to a considerable extent by the latter. The situation seems to be made possible by the fact that the Dental Corps and the Medical Corps are both under the Medical Department . . . Expansion of the Navy Dental Corps seems to have been held in check by overlapping functioning of the Medical Corps, with the effect of limiting administrative authority of the Dental Corps. That such subordination hampers the professional operation of the Dental Corps is fairly obvious."

Another bill, authorizing dental officers to exercise full powers of command, and sponsored by the Secretary of War, was also before Congress last month. It was expected to pass without opposition. The bill would give officers of Dental Corps the same rights already enjoyed by officers of the medical, veterinary, pharmacy, medical administrative, and sanitary corps. The only other group now denied similar rights is the Nurse Corps.

Under older laws, dental officers were empowered to command only their corps personnel—a restriction in effect since dentists were first commissioned in 1911. But Secretary Stimson has declared that "The training received by officers of the Dental Corps qualifies them professionally for command to the same extent as officers of other corps of the Medical Department, and there are many occasions when it would be most desirable that they be qualified by law to exercise such command."

Kickbacks

Nine physicians lost their licenses to handle workmen's compensation cases: 263 were suspended from such practice for periods ranging from a month to two years; seventy-two were reprimanded; ten were exonerated; 302 were yet to have hearings; and 343 in the armed forces had their cases filed for the duration. Such was the first penalty report issued last month by New York State Industrial Commissioner Edward Corsi as a result of the kickback scandal uncovered by the Moreland Act inquiry. The announcement covered only Kings County (Brooklyn); reports on accused physicians in Manhattan, the Bronx, Queens and Westchester County were to follow.

The penalties capped a series of individual hearings conducted by the Medical Society of Kings County. More than 1,000 Brooklyn doctors had been charged by the More-

Hemorrhoidal Anesthetic

PROCAINE BUTYRATE—Rorer

in suppository form

Penetrates and anesthetizes the mucous membrane. Most sufferers obtain relief in *5 minutes or less.*

THE FORMULA:

Procaine Butyrate-Rorer 10%
Ephedrine 0.5%
Cresol 0.1%

At your prescription pharmacy: Boxes of 12 Suppositories. Samples and literature promptly on request.

•Procaine Butyrate-Rorer (The Butyric Acid Salt of Basic Procaine) Aromatic white crystalline powder. Discovered 1933 in Research Laboratories of William H. Rorer, Inc. Creates more powerful, longer-lasting and *less toxic* local anesthesia than Procaine HCl U.S.P. Is used both topically and hypodermically. Available in variety of ready to use forms, as well as in C. P. Crystals.
•U. S. Patent No. 217582

WILLIAM H. RORER, Inc. Est. 1910
Drexel Building, Independence Square, Philadelphia 6, Pa.

and investigators with taking kickbacks ranging from $1 to $1,127 during 1942. Among those suspended were five roentgenologists who had paid out rebates for referrals.

For many years, the state compensation law had specifically forbidden kickbacks, but only under penalty of the loss of one's compensation license. Recently, the law was amended, making the practice a misdemeanor. Hence, the penalties meted out were less severe than would currently apply—for the investigation was conducted before the law was changed.

Commissioner Corsi, however, hinted that further punishment might yet hit the guilty ones: Their non-compensation practices might be subjected to review by the State Education Department, which Mr. Corsi said would unquestionably "ask for all the information we have.

"It is far from a pleasant duty to take this action against such a large group of professional people," the commissioner commented. "But this is an instance wherein the protection of the public welfare transcends personal preference." He added that the condition was "one that men privileged to be a part of such a noble profession should never have permitted to exist." Those who knowingly took small kickbacks from commercial firms he labeled as deserving only "utter disgust for endangering their reputation for the insignificant sum of a dollar or two."

Prepaid Ward Care

A ward-care Blue Cross plan, sold only on a payroll deduction basis, has been instituted by the Associated Hospital Service of New York. The monthly cost is 56 cents for an

[*Continued on page 133*]

individual and $1.32 for a family. Designed for those who cannot afford the regular premium for semiprivate accommodations, the new plan will reach "a substantial number of persons who normally are forced to accept hospital care in wards on a charity basis."

No Choice

Even if medical services furnished by his self-insured employer are "clearly inadequate or incompetent," an injured Ohio worker does not have the right at the employer's expense "to substitute services of his own choice" without industrial commission authorization, according to a recent opinion of the state's attorney general.

Medical Union

"The sooner we stop all this nonsense about unionizing the medical profession the better."

Thus the Westchester County (N.Y.) Medical Society in appraising the Association of American Physicians and Surgeons.

The Westchester Association characterized as "the piece de resistance on the menu" of the AAPS a by-law which binds a member to agree that where 75 per cent of eligible civilian practitioners in his county have joined the association, "he will not carry on professional relations nor cooperate with any non-member therein."

Even if medical unionism could be made to work ("which it couldn't") the association wondered how much real coercive power a union of 150,000 physicians would have. "It is absurdly naive to imagine that the majority of physicians would stand together in any effort to block a proposal strongly favored by the public merely because the physicians felt that their economic status might be adversely affected by such a proposal."

Chides AMA

Officials of the American Medical Association who have "violently attacked" the medical and hospital insurance features of the Wagner-Murray-Dingell bill, according to the Washington Post, "have contributed very little to sober consideration of the measure on its merits by referring to it as 'socialized medicine.'

"If this is socialism," a recent Post editorial continued, "then so is the public school system. Good health, like good education, is one of the cornerstones of a democratic society. Under our present system of private medical practice, great portions of our population are compelled to go without adequate medical care, either because they cannot afford to pay for it and will not ask for charity, or because they live in rural areas to which doctors are not attracted. Un-

'My Most Interesting Experience'

¶MEDICAL ECONOMICS will pay $5-$10 for an acceptable description of the most exciting, amusing, amazing, or embarrassing incident that has occurred in your practice. Contributors may remain anonymous upon request. Address Medical Economics, Rutherford, N.J.

der the Wagner-Murray-Dingell bill, workers would be able to pay, through insurance, for their own medical and hospital care, and doctors would be able, in general, to earn better incomes.

"The various aspects of the proposed insurance program require, of course, the most careful study and consideration. We do not suggest any slapdash validation of them. But it is by no means too early, in our opinion, for Congress to start work on a program of this sort. The need is beyond denial. A genuine and comprehensive system of social security is the best possible foundation on which to build our postwar hopes."

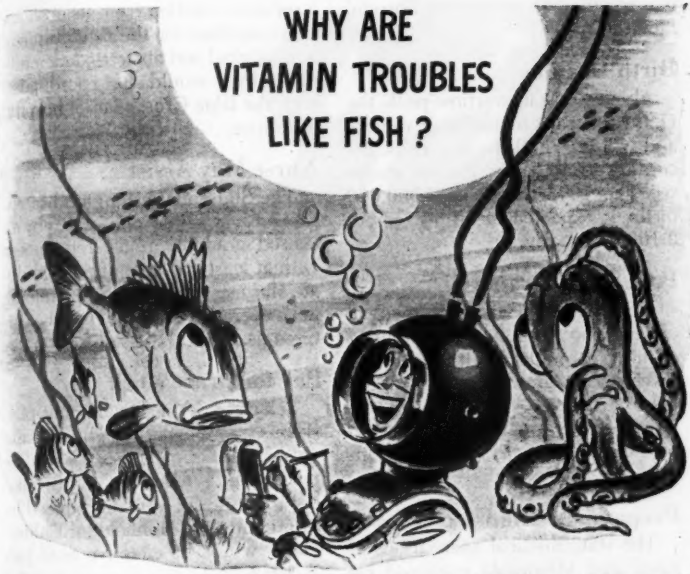
Job Dispensing

To physicians who find it necessary to recommend outdoor work for patients, the Donaldson Baking Co. of Columbus, Ohio, addressed a full page advertisement in the local medical society bulletin. It said: "If you have occasion to recommend an outdoor occupation to any of your patients, and you believe that they are physically qualified for our type of work, we would be very glad to talk to them." The company offered "clean, pleasant, and healthful outdoor activity with an opportunity to earn a good weekly income."

How? Delivering baked goods to 200 homes daily.

Veterans' Hospitals

A Senate-approved bill, authorizing $500,000,000 for construction of additional hospital facilities for war veterans, was being considered by the House of Representatives last month in amended form. The new version would authorize the appropriation, from time to time, of "such sums as may be necessary for the



MANY vitamin deficiencies, like fish, run in schools—more than one deficiency to a patient.

For treating *multiple* vitamin deficiency, you have a potent ally in IMPROVED Ol-Vitum—the "8-Vitamin" Capsules. Each Ol-Vitum capsule is *complete* as far as accepted daily requirements are concerned.

Each capsule contains the following 8 vitamins—A, B_1, B_2, B_6, C, D, Niacin Amide and Pantothenic Acid. Each capsule supplies the following ratio to minimum daily requirements:

	Adults & Children over 12 yrs.	*Children 6 to 11 years, incl.*
Vitamin A	125%	166%
Vitamin B_1	150%	200%
Vitamin B_2 (G)	100%	*
Vitamin C	100%	150%
Vitamin D	250%	250%

*Requirements not established

(Minimum daily requirements for Niacin Amide or need in human nutrition for Vitamin B_6 or Pantothenic Acid not established.)

IMPROVED Ol-Vitum Capsules are a most convenient way to assure adequate vitamin intake inexpensively. They are a product of "The House of Vitamins." International Vitamin Corporation are leaders in the research and production of vitamin products. They specialize solely in vitamin manufacture—have never made anything but vitamin products.

Improved

I.V.C. OL-VITUM

REG. U. S. PAT. OFF.

The "8-Vitamin" Capsule

construction of additional hospital facilities."

Birth Decline

Already past its wartime peak, the U.S. birth rate is declining rapidly and will fall until the war ends, according to a Census Bureau analysis. The 1943 record of 3,000,000 births is expected to drop to about 2,100,000 yearly.

P.G. Study Grants

Demobilized Canadian medical officers who enroll for post-graduate training in public health work will receive joint grants from the Province of Ontario, Canada, and the Rockefeller Foundation. Married men will be paid $200 a month; single men, $145.

Prepayment Plans

The state medical associations of Iowa and Minnesota prepared recently to ask for legislative action on enabling acts permitting organization of prepaid medical care programs under professional sponsorship.

In Nebraska, the Omaha-Douglas County Medical Society received a recommendation from its economics committee for the establishment of a surgical and obstetric indemnity plan, that would be coordinated with the Blue Cross plan of hospital insurance.

Nurse May Assist

The State of Washington has approved a wartime plan whereby licensed graduate registered nurses with at least one year of post-graduate surgical experience and training in an accredited hospital may be certified as surgical assistants.

Pay for Draft Work

Selective Service examining physicians, members of local boards, and government appeal agents would be paid at the rate of $600 a year, under the terms of a bill introduced by Representative Holifield, of California. It would be effective as of July 1, 1943.

Universal Program

Cradle-to-grave socialized medicine has been recommended to all nations participating in the recent International Labor Conference. The recommendations, adopted by over-

In marked contrast

to crude coal-tar ointments

Unlike crude coal-tar ointments, PRAGMATAR seldom gives rise to local irritative manifestations.

Furthermore, it can, in most cases, be safely applied to any part of the body.

This is *in marked contrast to crude coal-tar ointments*, which too often cause untoward idiosyncratic reactions when the spread of a dermatosis necessitates the extension of treatment to areas not originally involved.

Pragmatar—well described as "an ointment of general usefulness"—is highly effective in an unusually wide range of skin disorders.*

PRAGMATAR

(WITH SULFUR *and* SALICYLIC ACID)

A Significant Improvement in Tar-Sulfur-Salicylic Acid Ointments

* Indications and detailed directions for the use of Pragmatar may be found in the "Manual of Dermatology", recently prepared and issued under the auspices of the Division of Medical Sciences of the National Research Council.

SMITH, KLINE & FRENCH LABORATORIES, PHILADELPHIA, PA.

whelming vote of the delegates Philadelphia, embrace 114 points guarantee medical and dental ser ices, both general and specialize for all employed and indigent pe sons.

A beneficiary should have the righ it was said, "to select his family do tor and dentist among the partic pating general practitioners," and th additional right "subsequently t change his family doctor or dentis subject to giving notice within a pr scribed time, for good reasons, suc as lack of personal contact and co fidence."

Medical care would be provide either through social insurance, wit assistance for needy persons not y covered by such insurance, through a public medical service.

Free Plasma

Distribution of free blood plasm to all Michigan civilians who ne it has been started under a pl sponsored by the Red Cross and th State Department of Health. It is es timated that 50,000 persons will b served annually.

A typical community plasma ba now operates with a two to thr months' supply of plasma. Each ti a licensed practitioner draws on he signs a receipt which is sent to t health department at Lansing. T local bank then gets a fresh supp to offset the withdrawal.

Blood collected for processing sent daily to Lansing via a Sta provided mobile field unit of a do tor, four trained nurses and a drive The clinical equipment is move from city to city (except to thos that already have permanent blood donor services). Local Red Cro chapters obtain quarters, enlist vol unteer aides, and recruit donors.